Group / Association — Proof of Loss Accidental Dismemberment Insurance

CIGNA Group Insurance
Life • Accident • Disability
Connecticut General Life Insurance Company
Life Insurance Company of North America
CIGNA Life Insurance Company of New York

423244b
Rev. 06/2002

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information: or (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR ACCIDENTAL DISMEMBERMENT, PARALYSIS, LOSS OF SIGHT OR HEARING BENEFITS.
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/ Association Member:
- A. Complete the Employee / Association Member section of this form.
- B. Have the reverse side of the form completed and signed by the Attending Physician.
- C. Return the fully completed form to your Employer / Administrator who will submit the form to the assigned Claim Office.

To the Employer / Administrator
- A. Give the form to the Employee / Association Member for completion as indicated above.
- B. Complete Employer's / Administrator's section.
- C. Submit completed form to the assigned Claim office.

TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

NAME OF EMPLOYEE / ASSOCIATION MEMBER (Last Name) (First Name) (Middle Initial)	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)

POLICY NO.	DIVISION	OCCUPATION	WAS INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? (IF YES, ATTACH COPY). ☐ YES ☐ NO

PLEASE CHECK THE APPROPRIATE BLOCKS REGARDING THE INSURED'S EMPLOYMENT STATUS.

☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # ______ ☐ Salaried ☐ Full-time
☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time Hrs/wk ______

BASIC ANNUAL EARNINGS	DATE OF LAST CHANGE IN EARNINGS	DATE OF LAST INCREASE IN BENEFITS	AMOUNT OF INSURANCE	PREMIUM PAID THROUGH DATE

DATE HIRED / MEMBER OF ASSOCIATION	EFFECTIVE DATE OF INSURANCE	LAST DATE WORKED	PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD PREMIUM ______ EMPLOYEE'S CONTRIBUTIONS WERE MADE ON A ☐ PRE-TAX ☐ POST-TAX BASIS

WAS THE ABOVE CONSIDERED AN EMPLOYEE / ASSOCIATION MEMBER UNTIL DATE OF ACCIDENT? IF NOT, PLEASE EXPLAIN	WAS COVERAGE STILL IN EFFECT AT TIME OF ACCIDENT? IF NOT, PLEASE EXPLAIN

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

NAME OF DEPENDENT (First Name) (Middle Initial) (Last Name)	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX ☐ M ☐ F

RELATIONSHIP TO EMPLOYEE / MEMBER	AMOUNT OF DEPENDENT INSURANCE	DEPENDENT'S OCCUPATION	WAS THE DEPENDENT DISABLED PRIOR TO THE DATE OF THE ACCIDENT? ☐ YES ☐ NO	IF YES, DATE DISABILITY BEGAN

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER / ASSOCIATION	DIVISION	E-MAIL ADDRESS

ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE # ( )
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	DATE SIGNED

TO BE COMPLETED BY THE EMPLOYEE / ASSOCIATION MEMBER

WHERE AND HOW DID THE ACCIDENT HAPPEN? PLEASE DESCRIBE IN DETAIL.

DATE AND TIME OF ACCIDENT	WHAT DISEASES, ILLNESS OR INJURIES DID THE INJURED PERSON HAVE DURING THE PAST 3 YEARS?

INSURED'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/ WIDOWER	TELEPHONE # ( )	E-MAIL ADDRESS

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE INJURED PERSON DURING THE PAST 3 YEARS

NAME	COMPLETED ADDRESS	TREATMENT PERIOD

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. SIGNATURE OF EMPLOYEE / ASSOCIATION MEMBER:	DATE SIGNED

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to any CIGNA Company, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request.

This authorization, or a photostatic copy of the original, shall be valid from the date signed for the duration of the claim.

My authorized representative or I may revoke this authorization at any time as it applies to further disclosures by writing the Insurance Company. Prompt notice of revocation will then be given to all persons to whom the Insurance Company has disclosed protected health information in reliance to the original authorization as may be required or permitted by law. A valid authorization or court order for information does not waive other privacy rights.

NAME OF INJURED PERSON	SIGNATURE OF INJURED PERSON (Parent or Guardian, if person is a minor or incapacitated)	DATE SIGNED

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.

423244b 02/2002 Ptd. in U.S.A.

PHYSICIAN'S CERTIFICATE

PATIENT'S NAME	DATE OF BIRTH

1. PLEASE PROVIDE YOUR DIAGNOSIS.

2. PLEASE GIVE FULL DESCRIPTION OF THE INJURY.

3. ON WHAT DATE DID THE ACCIDENT OCCUR?.

4. ON WHAT DATE DID THE PATIENT FIRST CONSULT YOU FOR THIS INJURY?

5. WAS THE PATIENT TREATED BY OTHER PHYSICIANS FOR THE INJURY? IF SO, PLEASE LIST THE NAMES AND ADDRESSES IF KNOWN.

NAME	ADDRESS

6. IF SURGERY WAS PERFORMED, PLEASE INDICATE THE TYPE OF SURGERY PERFORMED AND THE DATE

7. PLEASE LIST THE NAME AND ADDRESS OF THE HOSPITAL WHERE THE SURGERY WAS PERFORMED IF KNOWN.

8. WERE THERE ANY COMPLICATIONS FOLLOWING SURGERY? IF SO, PLEASE EXPLAIN IN DETAIL

9. WAS THE DISMEMBERMENT / PARALYSIS / LOSS A DIRECT RESULT OF INJURIES SUSTAINED IN AN ACCIDENT, INDEPENDENT OF ALL CAUSES? IF NOT, PLEASE EXPLAIN IN DETAIL.

10. IF THIS CLAIM IS FOR DISMEMBERMENT, PLEASE MARK THE EXACT POINT OF AMPUTATION ON THE DIAGRAM.

11. IF THIS CLAIM IS FOR PARALYSIS, PLEASE INDICATE THE EXTENT OF PARALYSIS ON THE DIAGRAM. ADVISE IF THE PARALYSIS IS PERMANENT, COMPLETE AND IRREVERSIBLE.

12. IF THIS CLAIM IS FOR LOSS OF SIGHT, WHAT IS THE PATIENT'S VISUAL ACUITY? IS THE LOSS TOTAL AND PERMANENT? IS THE LOSS DUE TO THE ACCIDENT? PLEASE EXPLAIN IN DETAIL.
CAN THE VISION BE CORRECTED WITH EITHER SURGERY OR LENSES. IF SO, TO WHAT DEGREE?

13. IF THIS CLAIM IS FOR LOSS OF SPEECH OR HEARING, PLEASE ATTACH EXAMINATION AND LABORATORY RESULTS.

14. AT THE TIME OF THE INJURY, HAD THE PATIENT BEEN DIAGNOSED FOR ANY SPECIFIC DISEASE, ILLNESS OR OLD INJURIES? IF SO, PLEASE LIST THE DIAGNOSIS.

15. IF THIS CLAIM IS IS FOR LOSS OF USE, PLEASE IDENTIFY THE AREAS AFFECTED ON THE DIAGRAM.

16. WHAT PERIOD WAS THE PATIENT CONTINUOUSLY DISABLED? **FROM** **THROUGH**

17. HAS THE PATIENT BEEN RELEASED TO RETURN TO WORK? IF SO, PLEASE EXPLAIN IN DETAIL.

18. WOULD YOU CONSIDER THE INJURY TO BE WORK-RELATED? IF SO, PLEASE EXPLAIN IN DETAIL.

19. HAVE YOU PREPARED A REPORT OF THIS NATURE FOR ANY OTHER INSURANCE COMPANY? IF SO, PLEASE PROVIDE NAME AND ADDRESS

20. **REMARKS**				
DATE	PHYSICIAN'S NAME (Please Print)	SIGNATURE	DEGREE / SPECIALTY	TAX ID #
STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE	TELEPHONE NO.

IMPORTANT CLAIM NOTICE

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information ; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.