Cigna
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Phoenix, AZ 85078
1-800-754-3207 Toll Free
1-860-730-6460 Fax
E-mail Address*: accidentinjury/criticalillness@cigna.com

Group Critical Illness with Accidental Benefits and Healthy Living Wellness Benefits - Proof of Loss

Life Insurance Company of North America
Cigna Life Insurance Company of New York

*When transmitting communications, including documents, to this email address, please be sure to encrypt your message prior to sending. Cigna assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information.

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NEW YORK FRAUD WARNING: 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.

CAUTION: 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; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR CRITICAL ILLNESS WITH ACCIDENTAL BENEFITS AND HEALTHY LIVING WELLNESS BENEFITS.
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/Member
A. For all Benefits, complete pages 2 and 4 and review page 5.
B. If claiming Critical Illness Benefit, please complete Section A on page 3.
C. If claiming Accidental Benefit, please complete Section B on page 3.
D. If claiming Healthy Living Wellness Benefit, please complete Seciton C on page 3.

SECTION TO BE COMPLETED BY THE EMPLOYEE/MEMBER OR EMPLOYEE/MEMBER AND DEPENDENT

Name of Employee/Member *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Employee's/Member's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Telephone Numbers
Day Evening | Email Address

Policy Number(s) | Occupation

Please check all of the boxes that apply to the employee's/member's employment status and job classification. Hrs./Wk. ____
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Date Hired/Member of Assoc. | Date Last Worked | Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Were you an active Employee/Member until the date of your Critical Illness? ☐ Yes ☐ No If No, Please Explain

If you were not actively at work, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Other: _____
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged

Do you have health care coverage with a Cigna HealthCare plan? ☐ Yes ☐ No

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

Name of Dependent *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Relationship to Employee/Member | Dependent's Occupation | Was the Dependent Disabled prior to the date of the Critical Illness? ☐ Yes ☐ No | If Yes, Date Disability began

Dependent's Employer | Dependent's Employer's Telephone Number | Is Child ☐ Full-time student ☐ Part-time student

Name & Address of School *(City)* *(State)* *(Zip Code)* | Dependent Telephone Number

EMPLOYER/ASSOCIATION INFORMATION

Name of Employer/Association | E-Mail Address

Address *(Street)* *(City)* *(State)* *(Zip Code)* | Telephone # ( )

CERTIFICATION

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. | Date Signed

SIGNATURE OF EMPLOYEE/MEMBER OR AUTHORIZED REPRESENTATIVE:

The issuance of this form 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.

Name of Employee/Member *(Last Name)*	*(First Name)*	*(Middle Initial)*	Social Security No.
Claimant Name *(If other than Employee/Member)*:			Relationship to Employee/Member:

SECTION A: (REQUIRED FOR CRITICAL ILLNESS BENEFIT)

WHAT WAS THE SPECIFIC CRITICAL ILLNESS FOR WHICH THE CLAIM IS BEING MADE?	WHEN WAS THE CRITICAL ILLNESS FIRST DIAGNOSED?	HAS THE CLAIMANT EVER HAD THIS SAME OR A SIMILAR CONDITION? ☐ Yes ☐ No

☐ Initial/Additional Critical Illness ☐ Recurrence Critical Illness

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CRITICAL ILLNESS
(Please attach a separate list if additional space is needed)

IF THE CRITICAL ILLNESS REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY
(Please attach a separate list if additional space is needed)

SECTION B: (REQUIRED FOR ACCIDENTAL BENEFIT)

WHAT IS THE SPECIFIC COVERED LOSS FOR WHICH A CLAIM IS BEING MADE?

☐ Blindness ☐ Loss of speech ☐ Paralysis ☐ Coma

☐ Severe Burns ☐ Hearing: ☐ Left ear ☐ Right ear ☐ Both ears

DESCRIPTION/DATE OF ACCIDENT

LIST THE NAME, ADDRESS AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIAN'S OR TREATING FACILITIES FOR THE ACCIDENT.
(Please attach a separate list if additional space is needed)

SECTION C: (REQUIRED FOR HEALTHY LIVING WELLNESS BENEFIT)

WHICH HEALTH SCREENING TEST DID THE CLAIMANT HAVE PERFORMED?

	Date		Date
☐ Mammography		☐ Bone marrow testing	
☐ Pap Smear for women over age 18		☐ Breast ultrasound	
☐ Flexible Sigmoidoscopy		☐ CA 15-3 (blood test for breast cancer)	
☐ Hemocult Stool Specimen		☐ CA 125 (blood test for ovarian cancer)	
☐ Colonoscopy		☐ CEA (blood test for colon cancer)	
☐ Prostate Specific Antigen (for prostate cancer)		☐ Chest X-Ray	
☐ Stress test on a bicycle or treadmill		☐ Serum Protein Electrophoresis (blood test for myeloma)	
☐ Fasting Blood Glucose Test		☐ Thermography	
☐ Blood Test for Triglycerides			
☐ Serum cholesterol test to determin levels of HDL and LDL			

WHICH WELLNESS VISIT DID THE CLAIMANT HAVE PERFORMED?

	Date		Date
☐ Well Child Care - Visits, Labs and Immunizations		☐ Colorectal cancer screening	
☐ Osteoporosis screenings		☐ Lead poisoning screening	
☐ Routine gynecological exams		☐ Cancer screenings	
☐ Routine prostate exams		☐ Adult immunizations	
☐ General health exams		☐ Other: _____	

CLAIMANT'S OR AUTHORIZED PERSON'S SIGNATURE *(I authorize the release of any medical information necessary to process this claim).*

Signed: Date:

The issuance of this form is not the 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.

Disclosure Authorization

Claimant's Name: _____

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

_____ _____

(Claimant's Signature) (Date Signed)

_____ _____

(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America
Cigna Life Insurance Company of New York

IMPORTANT CLAIM NOTICE

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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: WARNING: 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.

Kansas 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 thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject 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.

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.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the 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.

CLEAR FORM CLICK TO PRINT