Pittsburgh Claim Service Center
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

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

423244d 06/2004

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; or (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: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas 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 Pittsburgh 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	**COMPLETE ADDRESS**	**TREATMENT PERIOD**

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

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): ______________________________

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative: ______________________________ Date: ______________

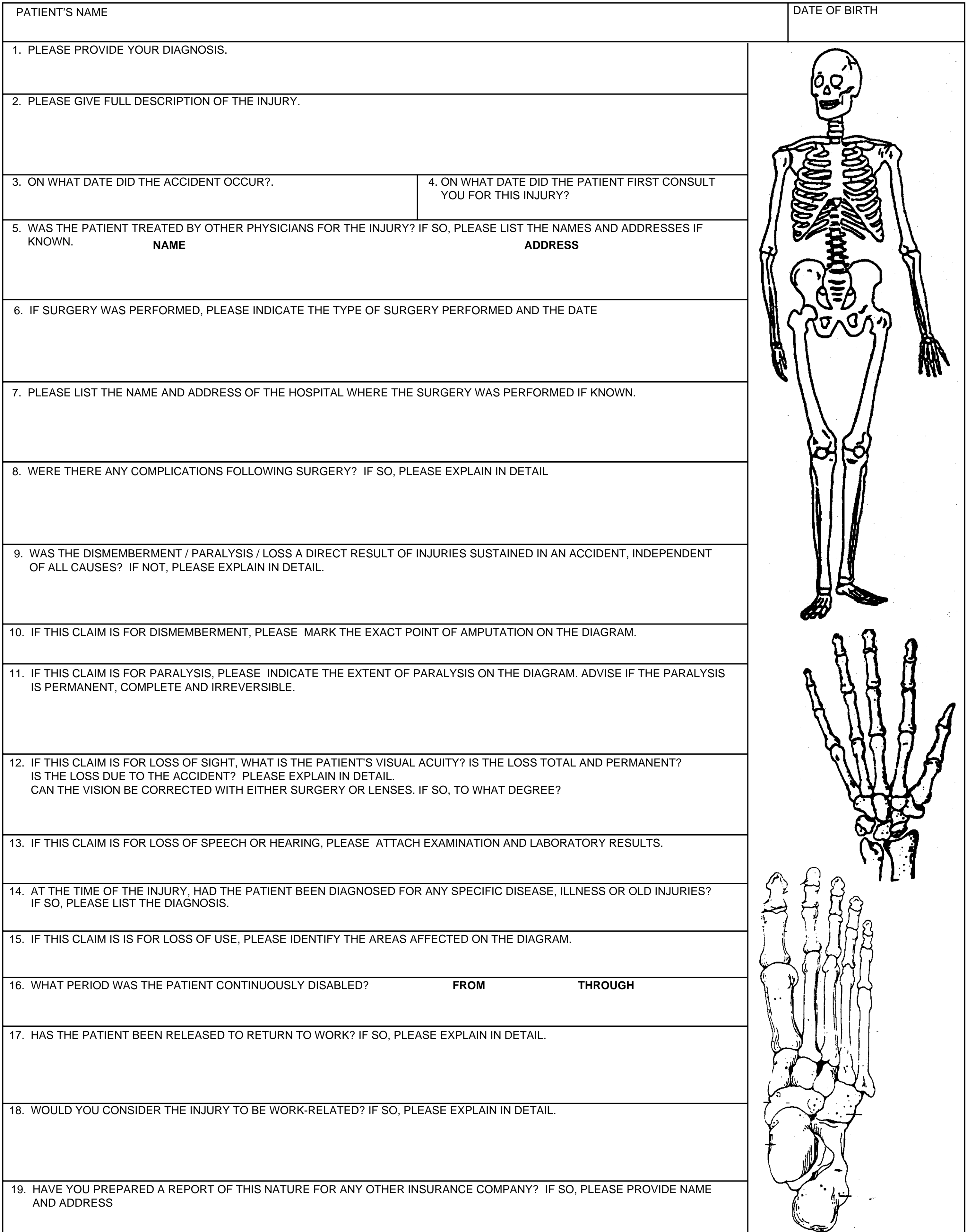
Relationship,
if other than Claimant: ______________________ Claimant's Social Security Number: ______________

Company Name: ______________________________

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

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.

CIGNAssurance Program SM

If your insurance benefit is $5,000 or more, CIGNA will automatically* open a free, interest-bearing account in your name. This account, called the CIGNAssurance Program SM is a safe, secure place to keep your proceeds while you decide how to best use them. A personal checkbook will be mailed to you, once your claim has been approved. Any amount that remains in the account will continue to earn interest at competitive rates. Both your principal and any interest you earn are completely guaranteed by Connecticut General Life Insurance Company, a CIGNA Company. The establishment of a CIGNAssurance SM account substitutes this guarantee for the obligation from the insurance company providing the life insurance or accidental death coverage. Checks are cleared through a draft account at State Street Bank. This account is not insured by the Federal Deposit Insurance Corporation or any federal agency. Account balances are the liability of the insurance company and the insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, CIGNA will send you a check for the total benefit amount.

***Residents of the state of Arkansas, Kansas, Minnesota, Nevada, or North Carolina, you may elect to participate in the CIGNAssurance Program SM by checking the box below and signing your name.**

☐ Please put my insurance proceed directly into the CIGNAssurance SM Account.

Signature ______________________ Date ______________

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.

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.

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 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.

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.

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.

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.

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.