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

CIGNA Group Insurance
Proof of Loss
Accidental Death Insurance

CIGNA Group Insurance
Life • Accident • Disability

Connecticut General Life Insurance Company
Insurance Company of North America
Life Insurance Company of North America
CIGNA Life Insurance Company of New York

LM-609297d (04/2004)

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, Maryland, New Jersey, New York, Oregon, Pennsylvania or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

1. The claim form must be completed by the person or persons making claim and accompanied by a certified copy of Certificate of Death.
2. A complete and certified copy of the Coroner's Report must be submitted in the event of death by violence. (If requested by the Company.)
3. This claim form must be executed by the person legally entitled to receive the money, who must state in what capacity he or she makes claim - whether as Beneficiary named in the policy. Assignee, Executor, Administrator, Guardian, or Trustee. If the Beneficiary is not of legal age, a Guardian must be appointed. If the insurance is payable to the insured's estate, an Administrator or Executor must be appointed. If the Claimant's Statement is executed by an Executor, Administrator or Guardian, a certified copy of such appointment must be submitted.
4. The Company reserves the right to require or obtain such additional evidence as it may deem necessary.
5. Before transmitting these papers to the company listed on the cover page. review all answers carefully and see that any necessary papers are attached in accordance with instructions given above.
6. If there is no designated Beneficiary, the Preference Beneficiary's Affidavit section must be completed and notarized.

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

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

Member Name	Member No.	Occupation

TO BE COMPLETED FOR DEPENDENT BENEFITS

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

Relationship To Member	Amount of Dependent Insurance	Dependent's Occupation

If Child ☐ Full Time Student ☐ Part Time Student	Name & Address of School

Please List Any Hospitals, Clinics or Physicians That Treated the Deceased During the Past 3 Years.

Name	**Complete Address**	**Treatment Period**

If the Deceased Had Any Other Insurance On His or Her Life, Please Provide the Details.

Name	**Amount**	**Effective Date**

TO BE COMPLETED FOR ACCIDENTAL DEATH BENEFITS

Where And How Did the Accident Happen? Please Describe in Detail.	Name of Common Carrier	Type of Common Carrier

Date and Time of Accident	What Diseases, Illnesses or Injuries Did the Deceased Have During the Past 3 Years?

BENEFICIARY INFORMATION

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

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

Under What Capacity or Under What Title Do You Make Claim? (See Instruction No. 3)	Is An Administrator or Executor To Be Appointed? If So, Please List Name and Address.

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.

CIGNAssurance Program℠

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℠ 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℠ 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℠ by checking the box below and signing your name.**

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

Preference Affidavit

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

IMPORTANT: This affidavit should be completed by a person who is a member of the first surviving class of the classes of beneficiaries described in questions 2, 3, 4, or 5 below who need only answer the questions up to and including the class of which he/she is a member. If none in those classes survives, than all questions must be completed by the executor or administrator of the insured's estate. If additional space is required, use reverse side showing number of question being answered.

_____ , being first duly sworn, depose and says:
(Name of Person Making Affidavit and Relationship to Insured)

That _____ , who died on _____ was Insured under
(Name of Insured) *(Insert Date of Death)*

Policy No. _____ in connection with the Group Life Insurance and/or Accidental Death and
(Insert Full Policy Number)

Dismemberment Policy of _____
(Insert Name of Group Policyholder - Employer)

I understand that in the absence of a beneficiary designated by the Insured or surviving at the death of the Insured, payment will be made in accordance with the terms of the applicable policy.

That for the purpose of inducing the Insurer to recognize the person(s) named herein as potential beneficiaries entitled to payment under the policy, the undersigned does answer as follows and agrees to reimburse the Insurer for any improper payment which is made based upon the information contained in this affidavit.

QUESTION	ANSWER (use back of form if needed)
1. Did the Insured designate a beneficiary who predeceased him? ☐ Yes ☐ No *If "YES", give name, relationship and date of death.*	NAME RELATIONSHIP | DATE OF DEATH
2. Did the Insured leave a widow or widower surviving? ☐ Yes ☐ No *If "YES", complete as indicated.*	NAME ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)* DATE OF BIRTH | SOCIAL SECURITY NUMBER DATE OF MARRIAGE TO EMPLOYEE | TYPE OF CEREMONY DATE OF DEATH *(if applicable)*
3. If the answer to Question 2 is "No", was the Insured survived by any children (including illegitimate and legally adopted children)? ☐ Yes ☐ No *If "Yes", give their names, addresses, dates of birth, social security numbers and dates of death if applicable.* *(Use reverse side if needed)*	NAME ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)* DATE OF BIRTH | SOCIAL SECURITY NUMBER DATE OF DEATH *(if applicable)*
4. If the answers to Questions 2 and 3 are "No", did the parents of the Insured or either of them survive him? ☐ Yes ☐ No *If "Yes", give names, addresses, dates of birth, social security numbers and dates of death.* *(Use reverse side if needed)*	NAME ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)* DATE OF BIRTH | SOCIAL SECURITY NUMBER DATE OF DEATH *(if applicable)*
5. If the answers to Questions 2, 3, and 4 are "No", was the Insured survived by any brothers or sisters of whole or half blood? ☐ Yes ☐ No *If "Yes", give their names, addresses, dates of birth, social security numbers and dates of death if applicable.* *(Use reverse side if needed)*	NAME ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)* DATE OF BIRTH | SOCIAL SECURITY NUMBER DATE OF DEATH *(if applicable)*

IMPORTANT: If answers to Questions 2, 3, 4 and 5 are "No", the foregoing must be completed in full by the executor or administrator of the Insured's estate and accompanied by a certified copy of the court appointment of said executor or administrator.

Subscribed and sworn to before me this _____ day of _____ , 20 __ __

_____ _____
(Notary Public) *(Signature of Affiant - First Name)* *(Initial)* *(Surname)*

IMPORTANT CLAIM NOTICE

California Residents: CAUTION: 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 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: 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.

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.

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.

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.