Group Long Term Disability

CIGNA Group Insurance
Life • Accident • Disability

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

500469 Rev. 05/2008

Group Long Term Disability

MAIL OR FAX TO: CIGNA Group Insurance Intake Service Center
12225 Greenville Ave., Suite 1000
Dallas, TX 75243
Facsimile (800) 642-8553

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CIGNA®

FRAUD WARNING: 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 reverse side of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

TO BE COMPLETED BY THE EMPLOYEE

PLEASE TYPE OR PRINT BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM
USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY

NAME (*Last, First, M.I.*)	SOCIAL SECURITY NO.	SEX ☐ M ☐ F	DATE OF BIRTH

MAILING ADDRESS *(Address where you may be reached during the next six months)* *(Zip Code)* | PHONE NUMBER *(Includes Area Code)*

Are you married, or do you have a domestic partner or civil union partner? ☐ Yes ☐ No
Do you have any children under age 25? ☐ Yes ☐ No
Do you have any handicapped children (regardless of age)? ☐ Yes ☐ No
If you answered "Yes" to any of the above questions, please list below.

NAME	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY NO.
1.		☐ M ☐ F		
2.		☐ M ☐ F		
3.		☐ M ☐ F		
4.		☐ M ☐ F		
5.		☐ M ☐ F		

LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS

DATE OF ACCIDENT OR BEGINNING OF SICKNESS	FIRST DATE YOU WERE UNABLE TO WORK	DATE YOU PLAN TO RETURN TO WORK

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, OR WORK-RELATED, DESCRIBE CIRCUMSTANCES)

NAMES OF ALL ATTENDING PHYSICIANS CONSULTED FOR THE DISABILITY | COMPLETE ADDRESS AND PHONE NUMBER | DATE FIRST CONSULTED

NAMES OF HOSPITALS | COMPLETE ADDRESS | DATE ENTERED-DATE DISCHARGED

Have you applied for Social Security Benefits? ☐ Yes ☐ No

If yes, please attach a copy of your Social Security notice for you and your dependents or a copy of your Social Security denial. If you have not applied, please do so as soon as possible. If you have not received a determination, please attach a copy of your receipt for application.

Are you receiving or eligible to receive:	$ Amount/Frequency	Date Began	Date Paid Thru
☐ Yes ☐ No Salary Continuance			
☐ Yes ☐ No State Disability Benefits			
☐ Yes ☐ No Group Disability Benefits			
☐ Yes ☐ No Workers' Compensation			
☐ Yes ☐ No Pension Benefits			
☐ Yes ☐ No No-Fault Auto Disability insurance			
☐ Yes ☐ No Any other Disability Income (please identify)			
☐ Yes ☐ No Veterans' Benefits			

Are you covered under a life insurance policy provided by a CIGNA underwriting company? ☐ Yes ☐ No
If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No
Have you elected CIGNA HealthCare medical insurance through your Employer? ☐ Yes ☐ No

If not, please provide the name of your medical insurance carrier _____

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE: **DATE:**

TO BE COMPLETED BY THE EMPLOYER
PLEASE COMPLETE IN FULL

NAME OF EMPLOYEE (*Last, First, M.I.*)	SOCIAL SECURITY NO.	ACCOUNT NUMBER

DATE HIRED	EFFECTIVE DATE OF EMPLOYEE'S LTD COVERAGE WITH CIGNA CO.	WAS EMPLOYEE'S LTD INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? ☐ Yes ☐ No IF YES, ATTACH COPY	
BASIC EARNINGS Wk. Mo.	DATE OF LAST CHANGE IN EARNINGS	LAST DATE(S) WORKED # Hrs.	DATE(S) RETURNED TO WORK

PLEASE CHECK THE APPROPRIATE BLOCKS:

☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full Time ☐ Part Time
☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly Hrs/wk: _____

HAS EMPLOYEE BEEN TERMINATED? ☐ Yes ☐ No	IF YES, DATE	REASON	
PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD DISABILITY PREMIUM(see Internal Revenue Code Section 105(a) and Regulations thereunder) %	EMPLOYEE'S CONTRIBUTIONS WERE MADE ON: ☐ Pre-or ☐ Post-tax basis	PREMIUM PAID THRU DATE	
WAS SALARY CONTINUED BEYOND LAST DAY WORKED? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	PAID THRU	
HAS EMPLOYEE RECEIVED SHORT TERM BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
HAS EMPLOYEE RECEIVED STATE DISABILITY BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
HAS EMPLOYEE FILED A WORKERS' COMPENSATION CLAIM? If yes, ☐ approved or ☐ pending? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU

NAME AND ADDRESS OF WC CARRIER AND WC CLAIM NUMBER

IS EMPLOYEE ELIGIBLE FOR GROUP PENSION ☐ Yes ☐ No	IF YES, MONTHLY AMOUNT $	EMPLOYEE % CONTRIBUTION To Pension _____ %	EFFECTIVE	IS THIS A ☐ DISABILITY PENSION ☐ EARLY RETIREMENT ☐ NORMAL RETIREMENT

LIST ANY OTHER SOURCE OF INCOME TO WHICH THE EMPLOYEE IS ENTITLED AS A RESULT OF THIS DISABILITY

OCCUPATION (ATTACH JOB DESCRIPTION IF AVAILABLE: IF NOT, DESCRIBE JOB DUTIES BELOW)

Was employee's job primarily ☐ sedentary or ☐ did it involve considerable physical activity?

AS CLOSELY AS POSSIBLE, PLEASE ESTIMATE THE PERCENT OF TIME SPENT (TOTAL PERCENTAGE MUST EQUAL 100%):

_____ Sitting _____ Walking _____ Stooping _____ Pushing _____ Carrying*
_____ Standing _____ Climbing _____ Bending _____ Lifting

*If job duties require lifting or carrying, indicate average and maximum weights handled. _____

Is this individual covered under a life insurance policy provided by a CIGNA underwriting company? ☐ Yes ☐ No
If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No

REMARKS

EMPLOYER DIVISION

ADDRESS	TELEPHONE NUMBER

AUTHORIZED REPRESENTATIVE PRINT: SIGNATURE:	DATE

HAVE ALL PAGES OF THE FORM BEEN COMPLETED IN FULL?
ATTACH THE ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY AND ANY OTHER DOCUMENTATION.

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" refers to: Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

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.

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 willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

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.