Pittsburgh Claim Service Center
P.O. Box 22328
Pittsburgh, PA 15222-0328

Group/Association - Proof of Loss
Life Insurance
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

LMS-612420d

Reset Form

Any field labeled "Required" or "Req." MUST be completed.
Dates should be entered in mm/dd/yyyy format.

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: *Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.*

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR LIFE INSURANCE OR ACCIDENTAL DEATH PROCEEDS ONLY.
COMPLETE THE FORM ACCORDING TO THE INSTRUCTIONS, TO AVOID DELAY OR RETURN OF THE FORM.
To The Employer/
Administrator:
A. Submit completed form to your assigned Claim Office with a certified Death Certificate and Beneficiary Designation.
B. If there is no designated Beneficiary, the Preference Beneficiary's Affidavit section must be completed and notarized.

SECTION TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

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

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

Insured's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced

Policy Number(s) | 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.
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried Hrs./Wk. _____
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Full-time ☐ Part-time

Basic Annual Earnings | Date of Last Change in Earnings | Date of Last Increase in Benefits | Amount of Insurance Basic: Supp: AD&D:

Date Hired/Member of Assoc. | Effective Date of Insurance | Date Last Worked | Date of Death | Premium Paid Through Date

Percentage of Insured's Contribution Toward Premium | Insured's Contributions Were Made on ☐ Pre-tax or ☐ Post-tax Basis | Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Was the above Considered an Employee/Association Member until the Date of Death? If Not, Please Explain

Was Coverage Still in Effect Through the Date of Death? If Not, Please Explain

EMPLOYER'S/ADMINISTRATOR'S CERTIFICATION

Name of Employer/Association Req. | Division | E-Mail Address

Address Req. *(Street)* *City* *(State)* *(Zip)* | Telephone Number Req.

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature Req. | Title Req. | Date Req. **01/16/2002**

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/Association Member | Amount of Dependent Insurance | Dependent's Occupation

Is Child ☐ Full-time student ☐ Part-time student | Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)*

Was the Dependent Totally Disabled? ☐ Yes ☐ No | If yes, Date Disability Began | Was Dependent Receiving Social Security or other Disability Benefits? ☐ Yes ☐ No

Employee/Insured: DOB: SSN:

TO BE COMPLETED IF CLAIM IS FOR ACCIDENTAL DEATH BENEFITS

Where and How Did the Accident Happen? Please Describe in Detail	Date and Time of Accident

SECTION TO BE COMPLETED BY THE BENEFICIARY

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

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

Relationship to Deceased	Daytime Telephone Number	E-Mail Address

Name and Address of Legal Guardian if Beneficiary is A Minor

Did the Deceased Have Other Insurance Coverage? ☐ Yes ☐ No	Type of Insurance	Policy Number(s)

Identify Insurance Carrier(s)

During the past 3 years, did the deceased use any form of tobacco product?

☐ Yes ☐ No

Please List Any Hospital, Clinics or Physicians That Treated the Deceased During the Past 5 Years.

Name	Complete Address	Treatment Period

I certify that the foregoing information is true, correct and complete to the best of my knowledge.

_____ _____

Beneficiary Signature Date

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 Deceased Signature of Personal Representative or Next of Kin Date Signed

_____ _____ _____

Resource Manager 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 CIGNA Resource Manager 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. You can take all or part of the money out of the account simply by writing a check for $250.00 or more. 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 CIGNA Resource Manager 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. 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, Nevada, or North Carolina, you may elect to participate in the CIGNA Resource Manager Program by checking the box below and signing your name.

☐ Please put my insurance proceed directly into the CIGNA Resource Manager 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.

Employee/Insured: DOB: SSN:

Preference Beneficiary's Affidavit

CIGNA Group Insurance
Life • Accident • Disability

☐ Connecticut General Life Insurance Company
☐ Insurance Company of North of America
☐ Life Insurance Company of North America

CIGNA

This affidavit relates to a claim for benefits under the policy identified below, issued by the company designated by: ☒ and hereinafter called the Company.

Policy Number	Certificate Number	Name of Deceased

NOTE: This affidavit is to be used whenever no beneficiary was designated or no designated beneficiary survived the deceased. It is to be completed only by the person or one of the persons within the first surviving class of the following classes of successive preference beneficiaries of the deceased: (1) widow or widower; (2) children; (3) parents; (4) brothers or sisters; (5) executor or administrator

The undersigned, for himself/herself, their heirs, executors, and assigns hereby agree to release and forever discharge the Company from any further liability under the above referenced policies and further agrees to indemnify the Company and to hold harmless from any and all claims, costs, expenses and damages which may result from the company's reliance on the representations made herein and payment in accordance therewith.

State or Province of _____)

County of _____) SS # _____ - _____ - _____

I, _____ residing at _____

_____ _____ , being first duly sworn, depose and state:
(city or town) (state or province)

WIDOW OR WIDOWER

That I am the surviving spouse of the deceased person named above.

The date of my birth is ____/____/____ Signed X _____

SON OR DAUGHTER

That the deceased person named above left no surviving spouse; that I am the child of the deceased; and that the deceased left no surviving children other than myself and those listed below:

Name	Address	SS #	Date of Birth

The date of my birth is ____/____/____ Signed X _____

FATHER OR MOTHER

That the deceased person named above left no surviving spouse or child; that I am a parent of the deceased; and the other parent is listed below:

Name	Present Address	SS #	Date of Birth

Signed X _____

BROTHER OR SISTER

That the deceased person named above left no surviving spouse, child or parent; that I am the brother/sister of the deceased; and that the deceased left no surviving brothers or sisters other than myself and those listed below:

Name	Address	SS #	Date of Birth

The date of my birth is ____/____/____ Signed X _____

EXECUTOR OR ADMINISTRATOR

That the deceased person named above left no surviving spouse, child, parent, brother or sister; that I am the executor or administrator of the estate of the deceased.

Signed X _____

Subscribed and Sworn To Before Me This _____ Day of _____ , _ _ _ _

(SEAL) _____
Notary Public or other official authorized to administer oaths

My Commission or Term Expires _____ / _____ / _____

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.