

**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-612420c

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	<i>(Last Name)</i>	<i>(First Name)</i>	<i>(Middle Initial)</i>	Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Address	<i>(Street)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip Code)</i>
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Insured's Marital Status  
 Single     Married     Widow/Widower     Separated     Divorced

Policy Number(s)	Occupation	Was insurance issued on the basis of a statement of physical condition? <i>(If yes, attach copy)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please check the appropriate blocks regarding the insured's employment status.

<input type="checkbox"/> Active	<input type="checkbox"/> Exempt	<input type="checkbox"/> Management	<input type="checkbox"/> Supervisory	<input type="checkbox"/> Union Local # _____	<input type="checkbox"/> Salaried	Hrs./Wk. _____
<input type="checkbox"/> Retired	<input type="checkbox"/> Non-Exempt	<input type="checkbox"/> Non-Management	<input type="checkbox"/> Non-Supervisory	<input type="checkbox"/> Non-Union	<input type="checkbox"/> Hourly	<input type="checkbox"/> Full-time
					<input type="checkbox"/> 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
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Percentage of Insured's Contribution Toward Premium	Insured's Contributions Were Made on <input type="checkbox"/> Pre-tax or <input type="checkbox"/> Post-tax Basis	Has an assignment been taken? <i>(If so please attach.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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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	Division
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Address	Telephone Number
<i>(Street)</i>	<i>(City)</i> <i>(State)</i> <i>(Zip)</i>

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

Signature	Title	Date
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### TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

Name of Dependent	<i>(Last Name)</i>	<i>(First Name)</i>	<i>(Middle Initial)</i>	Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Relationship to Employee/Association Member	Amount of Dependent Insurance	Dependent's Occupation
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Is Child <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student	Name & Address of School
<i>(Street)</i> <i>(City)</i> <i>(State)</i> <i>(Zip Code)</i>	

Was the Dependent Totally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date Disability Began
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**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
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**SECTION TO BE COMPLETED BY THE BENEFICIARY**

Name of Beneficiary <i>(Last Name) (First Name) (Middle Initial)</i>	Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address <i>(Street) (City) (State) (Zip Code)</i>	Relationship to Deceased	Daytime Telephone Number	

Name and Address of Legal Guardian if Beneficiary is A Minor

Did the Deceased Have Other Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Insurance	Policy Number(s)
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Identify Insurance Carrier(s)

During the past 3 years, did the deceased use any form of tobacco product?  
 Yes  No

Name	Complete Address	Treatment Period
Please List Any Hospital, Clinics or Physicians That Treated the Deceased During the Past 5 Years.		

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.



## 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.