

***Group/Association - Proof of Loss Short Term Disability Benefits***



**CIGNA Group Insurance**  
Life • Accident • Disability

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

500385 Rev. 03/2006

**Group/Association - Proof of Loss  
Short Term Disability Benefits**

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

**CIGNA Group Insurance**  
Life • Accident • Disability  
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**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 EMPLOYER / ADMINISTRATOR**

NAME OF EMPLOYEE/ASSOCIATION MEMBER (Last Name)	(First Name)	(Middle Initial)	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS (Street)	(City)	(State)	(Zip Code)	TELEPHONE # ( ) -	

POLICY NO.	OCCUPATION
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PLEASE CHECK THE APPROPRIATE BLOCKS REGARDING THE INSURED'S EMPLOYMENT STATUS.

<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"/> Full-Time
<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"/> Part-Time

BASIC EARNINGS PER WEEK	DATE OF LAST CHANGE IN EARNINGS	DATE HIRED / MEMBER OF ASSOCIATION	EFFECTIVE DATE OF INSURANCE
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WAS INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Attach Copy	EMPLOYEE'S / MEMBER'S CONTRIBUTIONS WERE MADE ON: <input type="checkbox"/> Pre-Tax Basis <input type="checkbox"/> Post-Tax Basis
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LAST DAY WORKED # of Hours: _____	DATE RETURNED TO WORK	PREMIUM PAID THROUGH DATE	% OF INSURED'S CONTRIBUTION TO PREMIUM
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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

PLEASE LIST ALL BENEFITS THAT THE INSURED IS RECEIVING OR ELIGIBLE TO RECEIVE AS A RESULT OF HIS/HER DISABILITY (E.G. SALARY CONTINUANCE, SICK PAY, STATE DISABILITY, WORKERS' COMPENSATION, ETC.).

BENEFIT	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THRU DATE

HAS EMPLOYEE/MEMBER BEEN LAID OFF? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE	REASON
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HAS EMPLOYEE/MEMBER BEEN TERMINATED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE	REASON
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**EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION**

NAME OF EMPLOYER / ASSOCIATION
DIVISION
ADDRESS (Street) (City) (State) (Zip Code) TELEPHONE # ( ) -

**TO BE COMPLETED BY THE CLAIMANT**

**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**

DATE OF ACCIDENT OR BEGINNING OF SICKNESS	DATE FIRST UNABLE TO WORK	DATE YOU PLAN TO RETURN TO WORK	LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS
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DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, DESCRIBE CIRCUMSTANCES AND ADVISE WHETHER IT OCCURRED AT WORK).	HAVE YOU HAD THE SAME OR SIMILAR CONDITION IN THE PAST? IF SO, PLEASE DESCRIBE IN DETAIL.
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PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED YOU FOR YOUR ILLNESS OR INJURY.		
<b>NAME</b>	<b>COMPLETE ADDRESS</b>	<b>TREATMENT PERIOD</b>

PLEASE DESCRIBE YOUR JOB DUTIES IN DETAIL. WHAT PERCENT OF YOUR JOB REQUIRES PHYSICAL LABOR?

PLEASE LIST ALL BENEFITS YOU ARE RECEIVING OR ELIGIBLE TO RECEIVE UNDER ANY OTHER GROUP INSURANCE, GOVERNMENT PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE.			
<b>BENEFIT</b>	<b>GROSS WEEKLY AMOUNT</b>	<b>DATE BEGAN</b>	<b>PAID THRU DATE</b>

ARE YOU COVERED UNDER A LIFE INSURANCE POLICY PROVIDED BY A CIGNA UNDERWRITING  YES  NO  
 IF YES, DOES THIS LIFE INSURANCE POLICY CONTAIN A WAIVER OF PREMIUM PROVISION?  YES  NO

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF AUTHORIZED REPRESENTATIVE \_\_\_\_\_ 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.

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

DIAGNOSIS AND CONCURRENT CONDITIONS, INCLUDING ICD-9 OR DSM-III CODE.

IS CONDITION DUE TO PREGNANCY?  Yes  No IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION IF APPLICABLE.

APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT	DATE OF DELIVERY	TYPE OF DELIVERY
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COMPLICATIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.
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DATES OF SERVICE - INCLUDE DATE OF NEXT APPOINTMENT (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT).

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", WHEN AND DESCRIBE	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No
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HAS PATIENT BEEN HOSPITAL CONFINED?  Yes  No IF "YES", CONFINED FROM \_\_\_\_\_ THRU \_\_\_\_\_

NAME AND ADDRESS OF HOSPITAL \_\_\_\_\_

NATURE OF SURGICAL PROCEDURE, IF ANY \_\_\_\_\_

INPATIENT  OUTPATIENT DATE PERFORMED \_\_\_\_\_

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED - (UNABLE TO WORK)	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.
From: _____ Thru: _____	

REMARKS: WE ARE INTERESTED IN ANY INFORMATION THAT WOULD BE HELPFUL TO YOUR PATIENT FOR EVALUATION OF THIS CLAIM.

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE
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DEGREE	SOCIAL SECURITY NUMBER	TAX IDENTIFICATION NUMBER
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STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	TELEPHONE
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## 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 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.