CRITICAL ILLNESS CLAIM FORM INSTRUCTIONS

Please complete the claim form in its entirety, including supporting medical documentation.

- ✓ Have your Physician complete **Section 7: Physician Statement. This is the preferred option for the fastest claim processing time.**

  OR

- ✓ All medical records related to the covered Critical Illness, including pathology if applicable.

Note: the claim review process will start once we receive all documentation supporting your claim.

File this claim form using one of these methods:

Email SuppHealthClaims@Cigna.com

Mail Cigna Supplemental Health Solutions
P. O. Box 188028
Chattanooga, TN 37422

Additional documentation is required if you qualify for one of these special situations:

- If the claimant was hospitalized, also provide a UB-04 Form (can be requested from the hospital billing department) or documentation outlining room and board charges OR observation stay (with hospital arrival and discharge times) and Medical documentation with procedure and diagnosis codes associated with the date(s) of treatment.
- If claimant is a child dependent who is 26 or more years old and has a mental or physical handicap that requires employee support, also include the SSDI Award letter.
- If you are filing a claim on behalf of an insured claimant who is deceased, also provide the death certificate AND a disclosure authorization for the deceased, which can be obtained from the employee's Human Resources department.

Cigna Healthcare Supplemental Health Solutions
Critical Illness Intake Form

CLEAR FORM

This document is confidential and proprietary to Cigna Healthcare

Note: * = Required field

Note: Claimant must complete Sections 1-6.

Have your Attending Physician complete Section 7 as proof of diagnosis for fastest claim processing.
We will contact you if we need additional information to process the claim.

SECTION 1: EMPLOYEE INFORMATION

Name *(First & Last)*:*	Social Security Number:*	Date of Birth *(mm/dd/yyyy)*:*

Address:*	Daytime Phone Number:*

City:*	State:*	Zip Code:*	Email Address:*

Was the employee considered actively at work on the date of the incident?* ☐ Yes ☐ No

If no, what was the reason the employee was not actively at work?*
☐ Family Leave (FMLA) ☐ Unpaid Leave of Absence
☐ Paid Leave of Absence ☐ Other:

Does the employee have health care coverage with Cigna? ☐ Yes ☐ No

SECTION 2: EMPLOYER INFORMATION

Name of Employer *(at time of claim)*:*	Group Policy Number:

SECTION 3: CLAIMANT DEMOGRAPHIC INFORMATION *(Complete for Spouse or Child claim only)*

Name *(First & Last)*:*	Date of Birth *(mm/dd/yyyy)*:*	Relationship to Insured:*

Address:*

City:*	State:*	Zip Code:*	SSN: ☐ Does not have SSN

Does the claimant have health care coverage with Cigna? ☐ Yes ☐ No

SECTION 4: CHILD'S ADDITIONAL INFORMATION: *(Complete for Child claim only)*

Is the Child a full-time student?* ☐ Yes ☐ No	If Child is not a full-time student, is he/she totally disabled?* ☐ Yes ☐ No	If adult child is disabled, please provide the SSDI Award Letter.*

SECTION 5: DESCRIPTION OF YOUR CRITICAL ILLNESS

SECTION 6: LIST OF HOSPITALS, CLINICS OR PHYSICIANS

Physician/Facility Name:*	Specialty:	Phone Number:*	Fax Number:
Address:*		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	

SECTION 7: CRITICAL ILLNESS PHYSICIAN'S STATEMENT

Below is a list of all conditions outlined in this form *(please fill out the applicable section)*:

Cancer
- Carcinoma in Situ
- Invasive Cancer
- Skin Cancer

Vascular Condition
- Advanced Heart Failure
- Aortic & Cerebral Aneurysm
- Coronary Artery Disease
- Heart Attack
- Stroke

Nervous System Condition
- Parkinson's Disease

Infectious Condition
- Severe Sepsis

Other Specified Condition
- Advanced Obesity
- Benign Brain Tumor
- Blindness
- Crohn's Disease
- End-Stage Renal (Kidney) Failure
- Major Organ Failure
- Paralysis
- Pulmonary Embolism

Note: The patient may or may not have coverage for all listed conditions. Patient may also have coverage for additional conditions not listed. Coverage is determined by the patient's policy.

For Any Condition Not Listed

Diagnosis *(include ICD 10 Code):* Confirmed Diagnosis Date:

Note: If the patient has a condition that is not listed in the section above, please supply all medical documentation necessary to verify the diagnosis and associated diagnosis date.

History *(must fill out for any condition)*

When did the current symptoms first appear?	Confirmed Diagnosis Date:

Has the patient ever had the same or a similar condition? (If "yes," provide date and description.) ☐ Yes ☐ No

Note: Only the conditions listed below may be covered. If the patient does not have one of the specific illnesses listed below, the claim may not be eligible.

Cancer *(Please attach pathology report)*

Initial diagnosis date:	Any subsequent diagnosis dates:

Carcinoma in Situ (continued on next page)**

Did the patient have a malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose?

☐ Yes ☐ No

SECTION 7: CRITICAL ILLNESS PHYSICIAN'S STATEMENT (cont'd)

Carcinoma in Situ** (cont'd)

Did the patient have prostate cancer that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale?

☐ Yes ☐ No

**Does NOT include pre-malignant conditions or conditions with malignant potential, skin cancer or invasive cancer.

Invasive Cancer**

Did the patient have a disease involving an organ of the body which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells?

☐ Yes ☐ No

FOR GROUPS SITUSED IN OREGON – Was there a disease involving an organ of the body which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells?

☐ Yes ☐ No

Is the diagnosis the recurrence or spread (metastasis) of a previously diagnosed cancer where the patient has not undergone any form of treatment for the previously diagnosed invasive cancer for a period of 1 year?

☐ Yes ☐ No

**Does NOT include pre-malignant conditions or conditions with malignant potential, carcinoma in situ or skin cancer.

**FOR GROUPS SITUSED IN OREGON - Does NOT include:

1. Pre-malignant conditions or conditions with malignant potential;
2. Carcinoma in situ;
3. Basal cell carcinoma;
4. Squamous cell carcinoma of the skin, unless metastatic disease develops;
5. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ; or
6. A prostate tumor that is classified as T-1a,b, or c, N-0, and M-0 on a TNM classification scale.

Skin Cancer

Did the physician take a tissue specimen that shows basal cell carcinoma, squamous cell carcinoma or melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm?

☐ Yes ☐ No

Vascular Conditions *(Please attach associated operative report, lab report, or test results)*

Procedure Date:

Advanced Heart Failure**

Did the patient have one of the following diagnostic tests that shows abnormal left ventricular function consistent with advanced heart failure - echocardiogram, nuclear scan, or catheterization?

☐ Yes ☐ No

Did the patient have a blood test showing elevated BNP of 400 or greater consistent with advanced heart failure?

☐ Yes ☐ No

Does the physician confirm that the patient displays the clinical signs of advanced heart failure and recommends the patient be inpatient in a hospital?

☐ Yes ☐ No

Did the patient show signs of fluid overload such as lower extremity edema?

☐ Yes ☐ No

Did the patient show signs of accumulation of fluid in the abdomen (ascites) and/or lungs (pulmonary edema)?

☐ Yes ☐ No

In the event of death, does the autopsy confirmation and/or death certificate identify cardiomyopathy as the cause of death?

☐ Yes ☐ No

**Does NOT include heart attack, coronary artery disease or arrhythmias.

SECTION 7: CRITICAL ILLNESS PHYSICIAN'S STATEMENT (cont'd)

Aortic & Cerebral Aneurysm**

Was there a localized, blood-filled dilation of a natural blood vessel caused by weakening of the vessel wall in the aorta or cerebral blood vessels for which a physician has prescribed repair?

☐ Yes ☐ No

In the event of death, does the autopsy confirmation and/or death certificate identify non-traumatic aortic or cerebral aneurysm as the cause of death?

☐ Yes ☐ No

**Does NOT include any surgical repair of complications resulting from prior repair of an aneurysm.

Coronary Artery Disease

Did the patient have a narrowing or blockage of the inner lining of the coronary arteries by lipid-bearing plaques, which restricts blood flow to the heart by at least 70% for any one occlusion or 50% for any two or more?

☐ Yes ☐ No

Heart Attack

Was there an ischemic death of a portion of the heart muscle confirmed by diagnostic testing through:

1. Electrocardiographic (EKG); and,
2. Elevation of cardiac enzyme markers of myocardial injury?

☐ Yes ☐ No

In the event of death, does the autopsy confirmation and/or death certificate identify cardiomyopathy as the cause of death?

☐ Yes ☐ No

Stroke**

Was there a cerebrovascular event resulting in damage of brain tissue as a result of ischemia or hemorrhage and confirmed by findings on neuroimaging studies, including brain CT, MRI, MRA or similar diagnostic study, or a lumbar puncture (spinal tap)?

☐ Yes ☐ No

At least 96 hours after the event, was there:

i. Clinical evidence of persistent neurological deficits diagnosed by a physician; or

ii. Confirmatory findings on neuroimaging studies, including Brain CT, MRI, MRA, or similar diagnostic study, or lumbar puncture (spinal tap) consistent with a cerebrovascular event?

☐ Yes ☐ No

In the event of death, does the autopsy confirmation and/or death certificate identify stroke as the cause of death?

☐ Yes ☐ No

**Does NOT include transient ischemic attack, brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting the eye or optic nerve and ischemic disorders of the vestibular system.

Nervous System Conditions

Parkinson's Disease

Was there a loss of the neurotransmitter dopamine that lead to at least three of the following signs?

a. Tremors at rest
b. Slowed, physical movement (bradykensia) or difficulty initiating movement
c. Difficulty with speech (monotone voice, lack of inflection, etc.)
d. Muscular rigidity
e. Inexpressive face
f. Festinating gait
g. Rapid, persistent blinking (blephoraspasm)

☐ Yes ☐ No

SECTION 7: CRITICAL ILLNESS PHYSICIAN'S STATEMENT (cont'd)

Infectious Conditions**

Severe Sepsis

Was there a severe bacterial infectious disease that has spread to the bloodstream resulting in both of the following:

1. Organ dysfunction (failure of the respiratory, kidney, renal, cardiovascular, gastrointestinal tract, central nervous or blood coagulation systems to perform their normal functions); and
2. Blood pressure of less than or equal to 100 systolic?

☐ Yes ☐ No

**Does NOT include relapse of the underlying bacterial infection causing the severe sepsis.

Other Specified Conditions

Advanced Obesity

Was there a metabolic disorder that led to excess body fat for which a physician has prescribed:

Primary bariatric surgery; or

Date of diagnosis for primary bariatric surgery is the date when all of the following criteria have been met:

1. Is the individual is ≥ 18 years of age or has reached full expected skeletal growth and has evidence of either of the following:
   a. A BMI (Body Mass Index) ≥ 40; or
   b. A BMI (Body Mass Index) 35–39.9 with at least one clinically significant obesity-related comorbidity as well as any other medically recognized condition adversely affecting the patient's health. Clinically significant obesity-related comorbidity includes any of the following: i. symptomatic degenerative joint disease in a weight bearing joint; ii. Type II diabetes mellitus; iii. systolic blood pressure at least 140 mm Hg or diastolic blood pressure 90mm Hg or greater, despite medical management; iv. hyperlipidemia; v. coronary artery disease; vi. lower extremity lymphatic or venous obstruction; vii. obstructive sleep apnea or pulmonary hypertension; viii. evidence of nonalcoholic fatty liver disease or nonalcoholic steatohepatitis?

☐ Yes ☐ No

2. Has the physician, physician's assistant/nurse practitioner or registered dietician, other than the requesting surgeon, provided a statement that the patient has failed previous attempts to achieve and maintain weight loss by medical management?

☐ Yes ☐ No

3. Has a thorough multidisciplinary evaluation by a metabolic and bariatric surgery accreditation and quality improvement program (MBSAQIP) accredited bariatric program been performed within the previous 6 months which includes ALL of the following:
   a. A description of the proposed primary bariatric procedure(s)
   b. A separate medical evaluation and/or a recommendation for primary bariatric surgery from a physician/physician's assistant/nurse practitioner other than the requesting surgeon or associated staff
   c. unequivocal clearance for bariatric surgery by a mental health provider
   d. A nutritional evaluation by a physician or registered dietician

☐ Yes ☐ No

A revision or conversion of a prior primary bariatric surgery for the patient?

☐ Yes ☐ No

A physician prescribes primary bariatric surgery. The date of diagnosis for a revision or conversion of a prior primary bariatric surgery is the date the physician prescribes the revision or conversion of the prior bariatric surgery due to inadequate weight loss in accordance with the following criteria:

1. Is there evidence of full compliance with the previously prescribed postoperative dietary and exercise program?

☐ Yes ☐ No

2. Due to a technical failure of the original bariatric surgical procedure, has the individual failed to achieve adequate weight loss, which is defined as failure to lose at least 50% of excess body weight or failure to achieve body weight to within 30% of ideal body weight at least two years following the original surgery?

☐ Yes ☐ No

In the absence of a technical failure or major complication, individuals with weight loss failure greater than two years following a primary bariatric surgery procedure must meet the initial criteria for primary bariatric surgery.

SECTION 7: CRITICAL ILLNESS PHYSICIAN'S STATEMENT (cont'd)

Benign Brain Tumor

Has a biopsy been performed to confirm diagnosis? *(Attach biopsy test results)*

☐ Yes ☐ No

Was there a localized mass of abnormal cells in the brain that is non-cancerous, non-inflammatory, and non-infectious?

☐ Yes ☐ No

Blindness

Was there a clinically proven irreversible reduction of sight in both eyes, due to a disease or sickness resulting in sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity)?

☐ Yes ☐ No

Was there visual field restriction to 20 degrees or less in both eyes?

☐ Yes ☐ No

Crohn's Disease**

Was there a chronic inflammation disease of the digestive tract?

☐ Yes ☐ No

**Does NOT include irritable bowel syndrome or ulcerative colitis.

End-Stage Renal (Kidney) Failure

Was there a chronic irreversible failure of the function of both kidneys, such that regular hemodialysis or peritoneal dialysis is required to sustain life?

☐ Yes ☐ No

FOR GROUPS SITUSED IN IDAHO – Was there a chronic irreversible failure of the function of both kidneys, such that the patient's kidneys will no longer sustain life?

☐ Yes ☐ No

Major Organ Failure

Was there a life-threatening inability or lack of function of organs that is the result of sickness or disease and is not the result of physical Injury or trauma?

☐ Yes ☐ No

Did the physician recommend or prescribe that the patient undergo a human to human transplantation of the organ?

☐ Yes ☐ No

Paralysis**

Was there a complete, irreversible and permanent loss of the use of two or more non-severed limbs, as a result of a disease or sickness?

☐ Yes ☐ No

**Does NOT include paralysis as a result of stroke, multiple sclerosis and cerebral palsy.

Pulmonary Embolism**

Was there an obstruction of the pulmonary artery or its branches by thrombus that originated elsewhere in the body?

☐ Yes ☐ No

In the event of death, does the autopsy confirmation and/or death certificate identify pulmonary embolism as the cause of death?

☐ Yes ☐ No

**Does NOT include a blood clot confined to the lower extremities or pelvis.

Physician Information / Signature

Attending Physician Name *(First & Last)*:*		Degree:*	
Street Address:*			Phone Number:*
City:*	State:*	Zip Code:*	Fax Number:*

Attending Physician Signature*

Date Signed*

If **Section 7: Physician's Statement** is not filled out, include proof of diagnosis.

We will contact you if we need additional information to process the claim.

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; (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 of this form: ***Alaska, Alabama, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia.***

New York Residents: FRAUD WARNING: 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.

Claimant's Signature*
(or Parent/Guardian if Claimant is under 18 years old)

Date Signed*

The issuance of this form is not the 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.

Disclosure Authorization

Claimant's Name *(can be Employee, Spouse, or Child)*:* _____

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; any of your social security disability advocates or representatives; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

_____ _____

Claimant's Signature*
(or Parent/Guardian if Claimant is under 18 years old)

Date Signed*

_____ _____

Print Name*

Date of Birth *(mm/dd/yyyy)*:*

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Cigna Health and Life Insurance Company, Life Insurance Company of North America (LINA), and New York Life Group Insurance Company of NY (NYLGICNY) (formerly Cigna Life Insurance Company of New York).

IMPORTANT CLAIM NOTICES

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California Residents: For your protection California law requires the following statement appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

Kansas 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 thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Hampshire Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Puerto Rico Residents: Caution: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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: 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.

Washington 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.

West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THESE POLICIES PAY LIMITED BENEFITS ONLY. THEY ARE NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DO NOT COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group insurance policies may contain exclusions, limitations, reduction in benefits, and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, review your plan documents or contact a Cigna representative.