Group/Association - 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
Great-West Healthcare Administered by CIGNA

Clear Fields

Group/Association - Short Term Disability Benefits

MAIL OR FAX TO: CIGNA Group Insurance
P.O. Box 709015
Dallas, TX 75370-9015
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 last page of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, 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 ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code) | TELEPHONE # ( )

POLICY NO. | OCCUPATION

PLEASE CHECK THE APPROPRIATE BLOCKS REGARDING THE INSURED'S EMPLOYMENT STATUS.

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

BASIC EARNINGS PER WEEK | DATE OF LAST CHANGE IN EARNINGS | DATE HIRED / MEMBER OF ASSOCIATION | EFFECTIVE DATE OF INSURANCE

WAS INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION?
☐ Yes ☐ No If Yes, Attach Copy

EMPLOYEE'S / MEMBER'S CONTRIBUTIONS WERE MADE ON:
☐ Pre-Tax Basis ☐ Post-Tax Basis

LAST DAY WORKED # of Hours: ______ | DATE RETURNED TO WORK | PREMIUM PAID THROUGH DATE | % OF INSURED'S CONTRIBUTION TO PREMIUM

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? ☐ Yes ☐ No | IF YES, DATE | REASON

HAS EMPLOYEE/MEMBER BEEN TERMINATED? ☐ Yes ☐ No | IF YES, DATE | REASON

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER / ASSOCIATION | DIVISION

ADDRESS (Street) (City) (State) (Zip Code) | TELEPHONE # ( )

EMPLOYER / ASSOCIATION
Print: Signature: Date:

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

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.

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED YOU FOR YOUR ILLNESS OR INJURY.

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

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.

BENEFIT	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THRU DATE

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 ____________________

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 IV-TR 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

COMPLICATIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

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? ☐ Yes ☐ No IF "YES", WHEN AND DESCRIBE	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ Yes ☐ No

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) From: Thru:	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

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

DEGREE	SOCIAL SECURITY NUMBER	TAX IDENTIFICATION NUMBER

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	TELEPHONE

Disclosure Authorization

CIGNA

Claimant's Name: ______________________________

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; 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; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, 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.

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.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

______________________________ (Claimant's Signature)

______________________________ (Date Signed)

______________________________ (Print Name)

______________________________ (Date of Birth)

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: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

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.

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: 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.