Cigna
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

Group / Association — Proof of Loss
Accidental Dismemberment Insurance

Connecticut General Life Insurance Company
Life Insurance Company of North America
Cigna Life Insurance Company of New York
Great-West Healthcare Administered by Cigna

423244d Rev. 03/2017

NEW YORK 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.

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: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR ACCIDENTAL DISMEMBERMENT, PARALYSIS, LOSS OF SIGHT OR HEARING BENEFITS.
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/ Association Member:
A. Complete the Employee/Association Member section of this form, review the Cignassurance® Program Disclosure Notice and the Important Claim Notice, and sign the Disclosure Authorization.
B. Have the Physician's Certificate completed and signed by the Attending Physician.
C. Return the fully completed form to your Employer / Administrator who will submit the form to the assigned Claim Office.

To the Employer / Administrator
A. Give the form to the Employee / Association Member for completion as indicated above.
B. Complete Employer's / Administrator's section.
C. Submit completed form to the Pittsburgh Claim office.

SECTION TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR FOR EMPLOYEE AND DEPENDENT BENEFITS

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

ADDRESS (Street) (City) (State) (Zip Code)

Insured's Marital Status ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Policy Number(s) | Occupation

Please check all of the boxes that apply to the insured's employment status and job classification. Hrs./Wk. _____

☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Basic Annual Earnings | Effective Date of Earnings | Employee's Division/Location

Amount of Insurance Basic AD&D: _____ Voluntary AD&D: _____ NOTE: Please provide proof of enrollment if claiming Voluntary AD&D

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

Percentage of Insured's Contribution Toward Premium
Basic: _____ % Voluntary: _____ %

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 the accident?
☐ Yes ☐ No If No, Please Explain

Was the above actively at work until the date of the Dependent's accident? ☐ Yes ☐ No
If No, indicate reason below.

If the employee was not actively at work immediately prior to his/her accident or Dependent's accident, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Other: _____
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged

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

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/ Member | Amount of Dependent Insurance | Dependent's Occupation | Was the Dependent Disabled prior to the date of the accident? ☐ Yes ☐ No | If Yes, Date Disability began

Dependent's Employer | Dependent's Employer's Telephone Number | Is Child ☐ Full-time student ☐ Part-time student

Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)* | School Telephone Number

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

Name of Employer / Association | E-Mail Address

Address *(Street)* *(City)* *(State)* *(Zip Code)* | Telephone # ( )

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. | Date Signed

SIGNATURE OF AUTHORIZED REPRESENTATIVE:

The issuance of this form is not an admission of the existence, nor does it recognize the validity, of any claim and is without prejudice to the company's legal rights.

TO BE COMPLETED BY THE EMPLOYEE / ASSOCIATION MEMBER

Name of Employee/Insured *(Last Name)*	*(First Name)*	*(Middle Initial)*	Social Security No.

WHERE AND HOW DID THE ACCIDENT HAPPEN? PLEASE DESCRIBE IN DETAIL.

DATE AND TIME OF ACCIDENT	WHAT DISEASES, ILLNESS OR INJURIES DID THE INJURED PERSON HAVE DURING THE PAST 3 YEARS?

INSURED'S MARITAL STATUS

☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/ WIDOWER

☐ DOMESTIC PARTNER RELATIONSHIP ☐ CIVIL UNION

TELEPHONE # ( )

E-MAIL ADDRESS

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE INJURED PERSON DURING THE PAST 3 YEARS

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

Do you have health care coverage with Cigna ? ☐ Yes ☐ No

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE / ASSOCIATION MEMBER:

DATE SIGNED

Cignassurance® 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 Cignassurance® Program, is a convenient and secure place to keep your proceeds while you decide how to best use them. Please review the attached Cignassurance® Program Disclosure Notice for full details about the account.* Account balances are the liability of the insurance company and are not insured by the Federal Deposit Insurance Corporation or any federal agency. The insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, Cigna will send you a check for the total benefit amount.

*Please read the Cignassurance® Program Disclosure Notice before signing below.

I understand that if my benefit is $5,000 or more, I will receive a Cignassurance® account.

I understand that I may write a draft for the total amount in my account at any time.

I understand that the account balance may be reduced for any benefit payment by the insurance company made in error.

I acknowledge that, if I do not separately sign the Cignassurance® Section of this Claim Form, I am not participating in the Cignassurance® Program and that I will receive a single lump sum check for the proceeds due if my claim is approved.

Signature* Date

*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form 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.

Disclosure Authorization

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York
Great-West Healthcare Administered by Cigna

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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: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

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; 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; 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, 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.

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.

COMPLETE ONLY IF CLAIMING DISMEMBERMENT BENEFITS

PHYSICIAN'S CERTIFICATE

PATIENT'S NAME	DATE OF BIRTH

1. PLEASE PROVIDE YOUR DIAGNOSIS.

2. PLEASE GIVE FULL DESCRIPTION OF THE INJURY.

3. ON WHAT DATE DID THE ACCIDENT OCCUR?.

4. ON WHAT DATE DID THE PATIENT FIRST CONSULT YOU FOR THIS INJURY?

5. WAS THE PATIENT TREATED BY OTHER PHYSICIANS FOR THE INJURY? IF SO, PLEASE LIST THE NAMES AND ADDRESSES IF KNOWN.
NAME **ADDRESS**

6. IF SURGERY WAS PERFORMED, PLEASE INDICATE THE TYPE OF SURGERY PERFORMED AND THE DATE

7. PLEASE LIST THE NAME AND ADDRESS OF THE HOSPITAL WHERE THE SURGERY WAS PERFORMED IF KNOWN.

8. WERE THERE ANY COMPLICATIONS FOLLOWING SURGERY? IF SO, PLEASE EXPLAIN IN DETAIL

9. WAS THE DISMEMBERMENT / PARALYSIS / LOSS A DIRECT RESULT OF INJURIES SUSTAINED IN AN ACCIDENT, INDEPENDENT OF ALL CAUSES? IF NOT, PLEASE EXPLAIN IN DETAIL.

10. IF THIS CLAIM IS FOR DISMEMBERMENT, PLEASE MARK THE EXACT POINT OF AMPUTATION ON THE DIAGRAM.

11. IF THIS CLAIM IS FOR PARALYSIS, PLEASE INDICATE THE EXTENT OF PARALYSIS ON THE DIAGRAM. ADVISE IF THE PARALYSIS IS PERMANENT, COMPLETE AND IRREVERSIBLE.

12. IF THIS CLAIM IS FOR LOSS OF SIGHT, WHAT IS THE PATIENT'S VISUAL ACUITY? IS THE LOSS TOTAL AND PERMANENT? IS THE LOSS DUE TO THE ACCIDENT? PLEASE EXPLAIN IN DETAIL. CAN THE VISION BE CORRECTED WITH EITHER SURGERY OR LENSES. IF SO, TO WHAT DEGREE?

13. IF THIS CLAIM IS FOR LOSS OF SPEECH OR HEARING, PLEASE ATTACH EXAMINATION AND LABORATORY RESULTS.

14. AT THE TIME OF THE INJURY, HAD THE PATIENT BEEN DIAGNOSED FOR ANY SPECIFIC DISEASE, ILLNESS OR OLD INJURIES? IF SO, PLEASE LIST THE DIAGNOSIS.

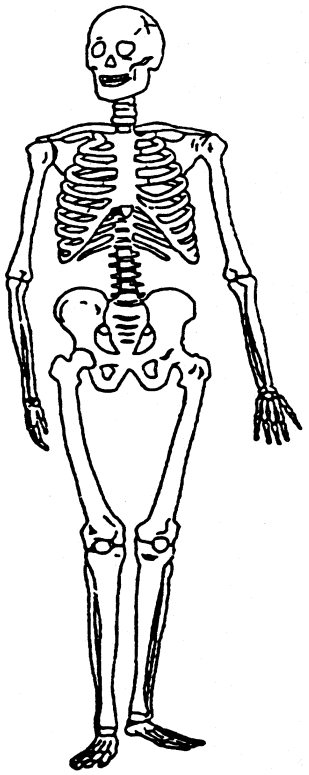
15. IF THIS CLAIM IS IS FOR LOSS OF USE, PLEASE IDENTIFY THE AREAS AFFECTED ON THE DIAGRAM.

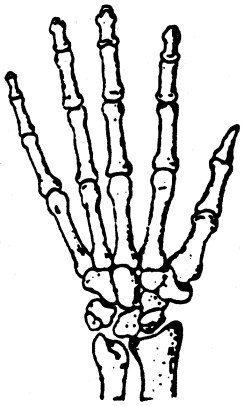
16. WHAT PERIOD WAS THE PATIENT CONTINUOUSLY DISABLED? **FROM** **THROUGH**

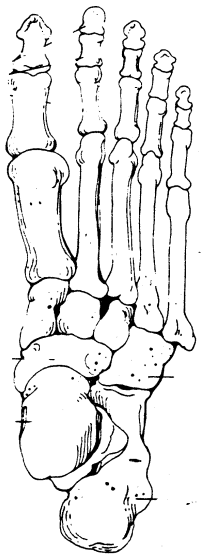
17. HAS THE PATIENT BEEN RELEASED TO RETURN TO WORK? IF SO, PLEASE EXPLAIN IN DETAIL.

18. WOULD YOU CONSIDER THE INJURY TO BE WORK-RELATED? IF SO, PLEASE EXPLAIN IN DETAIL.

19. HAVE YOU PREPARED A REPORT OF THIS NATURE FOR ANY OTHER INSURANCE COMPANY? IF SO, PLEASE PROVIDE NAME AND ADDRESS







20. **REMARKS**

DATE	PHYSICIAN'S NAME (Please Print)	SIGNATURE	DEGREE / SPECIALTY	TAX ID #
STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE	TELEPHONE NO.

Cignassurance® Program Disclosure Notice

Cignassurance® Program Disclosure

If your insurance benefit is $5,000 or more, Cigna will establish a free, interest-bearing draft account in your name. This account is a convenient and secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts (checks) will be mailed to you, once your claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. There are charges for the following special services: drafts returned unpaid ($10), stop payment ($12) and copy of draft or statement ($2).

You will receive a quarterly statement for your Cignassurance® account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. You may also check your account balance online at any time at www.cignassurance.com.

Drafts are cleared through a draft account at BNY Mellon Bank (contact information on next page). Cigna's obligation to pay is satisfied by depositing the total proceeds in the retained asset account. Drafts draw upon funds held by Cigna (whereas a "check" draws upon funds held by a banking institution). You may write an unlimited number of drafts, in any amount, at any time up to your account balance. If you wish to withdraw the proceeds in full, you can write a draft for the total amount of the account at any time. You also have the right to receive an initial lump-sum payment in the form of a bank check. Please note that Cigna reserves the right to reduce account balances for any payment made in error. You also have the right to name a beneficiary to your account. If an account becomes inactive (as defined by your State's Department of Insurance), Cigna will return any remaining balance held in a RAA to your State of residence if no named beneficiary can be located.

This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guarantee association. Please contact the National Organization of Life and Health Insurance website (www.nolhga.com) to learn more about the coverage limitations to the account under a state guaranty association.

All funds are held by the insurance company, or one of its affiliates, which, like a bank, may earn money on the invested amounts that exceed the interest credited to the account and the cost of the additional benefits and services described below. For beneficiaries under policies issued by Connecticut General Life Insurance Company (CGLIC) and Life Insurance Company of North America (LINA), the custodian of the account funds will be CGLIC. For beneficiaries under policies issued by Cigna Life Insurance Company of New York (CLICNY), the custodian of the accounts funds will be CLICNY.

Disclosure on Interest Earned

You earn an attractive interest rate on the funds in your Cignassurance® Program Account from the day it is established until the date it is closed. The Cignassurance® Program interest rate is reviewed weekly and will be based upon the previous week's Bank Rate Monitor Index (BRM) or any successor money market index. The BRM Index is the average annual effective yield earned on the money market accounts offered by 100 large US Bank and Thrifts across the country. Any amount that remains in the account will continue to earn interest at a rate equal to the national average bank money market rate.

Please call our toll-free number 855.836.0697 for the current rate. Both your principal and any interest you earn are guaranteed by the insurance company. Any interest earned on the account may be taxable and you should consult a tax, investment, or other financial advisor regarding tax liability and investment options. Interest earned on your account is compounded daily and is credited to your account on the fifth day of each month. All funds, including earned interest, are fully guaranteed by the insurance company.

If you have additional questions or would like additional information about the Cignassurance® Program, you can **call us at 800.570.3778**

Or write us at: Cignassurance® Program
PO Box 534029
Pittsburgh, PA 15253-4029

For further information, please contact your State Department of Insurance using the information provided on the next page.

Draft Accounts are setup by BNY Mellon Bank, located at 500 Ross Street, Pittsburgh, PA 15262.

The issuance of this notice 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 with respect to the insurance.

Cignassurance® Program Disclosure Notice

State Insurance Department Contact Information

Alabama
PO Box 303351
Montgomery, AL 36130
(334) 269-3550
www.aldoi.gov

Alaska
PO Box 110805
Juneau, AK 99811
(800) 467-8725
www.commerce.alaska.gov/ins

Arizona
2910 N. 44th Street, STE 210
Phoenix, AZ 85018
(602) 364-3100
www.id.state.az.us

Arkansas
1200 West Third Street
Little Rock, AR 72201
(800) 282-9134
www.insurance.arkansas.gov

California
300 South Spring Street,
South Tower
Los Angeles, CA 90013
(800) 927-4357
www.insurance.ca.gov

Colorado
1560 Broadway, STE 850
Denver, CO 80202
(800) 930-3745
www.dora.state.co.us/insurance

Connecticut
153 Market Street
Hartford, CT 06103
(800) 203-3447
www.ct.gov/cid

Delaware
841 Silver Lake Blvd.
Dover, DE 19904
(800) 282-8611
www.delawareinsurance.gov

Florida
200 East Gaines Street
Tallahassee, FL 32399
(850) 413-3140
www.floir.com

Georgia
2 Martin Luther King, Jr. Dr
West Tower, STE 704
Atlanta, GA 30334
(800) 656-2298
www.gainsurance.org

Hawaii
PO Box 3614
Honolulu, HI 96811
(808) 586-2790
www.hawaii.gov/dcca/ins

Idaho
700 West State Street
PO Box 83720
Boise, ID 83720
(208) 334-4250
www.doi.idaho.gov

Illinois
320 W Washington
Springfield, IL 62767
(866) 445-5364
www.insurance.illinois.gov

Indiana
311 W Washington Street,
STE 300
Indianapolis, IN 46204
(317) 232-2385
http://www.in.gov/idoi

Iowa
330 Maple St.
Des Moines, IA 50319
(877) 955-1212
www.iid.state.ia.us

Kansas
420 SW 9th Street
Topeka, KS 66612
(800) 432-2484
www.ksinsurance.org

Kentucky
PO Box 517
Frankfort, KY 40602
(800) 595-6053
www.insurance.ky.gov

Louisiana
1702 N. Third Street
PO Box 94214
Baton Rouge, LA 70802
(800) 259-5300
www.ldi.louisiana.gov

Maine
34 State House Station
Augusta, ME 04333
(800) 300-5000
www.maine.gov/pfr/insurance

Maryland
200 St. Paul Place, STE 2700
Baltimore, MD 21202
(800) 492-6116
www.mdinsurance.state.md.us

Massachusetts
1000 Washington Street,
STE 810
Boston, MA 02118
(617) 521-7794
www.mass.gov/doi

Michigan
PO Box 30220
Lansing, MI 48909
(877) 999-6442
www.michigan.gov/ofir

Minnesota
85 7th Place East, STE 500
Saint Paul, MN 55101
(651) 296-4026
www.insurance.mn.gov

Mississippi
PO Box 79
Jackson, MS 39205
(800) 562-2957
www.mid.state.ms.us

Missouri
PO Box 690
Jefferson City, MO 65102
(573) 751-4126
www.insurance.mo.gov

Montana
840 Helena Ave.
Helena, MT 59601
(406) 444-2040
www.sao.mt.gov

Nebraska
PO Box 82089
Lincoln, NE 68501
(877) 564-7323
www.doi.ne.gov

Nevada
1818 E. College Pkwy.,
STE 103
Carson City, NV 89706
(888) 872-3234
www.doi.nv.gov

New Hampshire
21 South Fruit Street, STE 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance

New Jersey
20 West State Street
PO Box 325
Trenton, NJ 08625
(800) 446-7467
www.state.nj.us/dobi

New Mexico
1120 Paseo De Peralta
PO Box 1269
Santa Fe, NM 87501
(888) 427-5772
www.nmprc.state.nm.us/id.htm

New York
One State Street
New York, NY 10004
(800) 342-3736
www.dfs.ny.gov

North Carolina
1201 Mail Service Center
Raleigh, NC 27699
(800) 546-5664
www.ncdoi.com

North Dakota
600 E. Boulevard Ave.
Bismarck, ND 58505
(800) 247-0560
www.nd.gov/ndins

Ohio
50 W. Town Street, STE 300
Columbus, OH 43215
(800) 686-1526
www.insurance.ohio.gov

Oklahoma
3625 NW 56th, STE 100
Oklahoma City, OK 73112
(800) 522-0071
www.ok.gov/oid

Oregon
PO Box 14480
Salem, OR 97309
(888) 877-4894
www.cbs.state.or.us/ins/index.html

Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120
(877) 881-6388
www.ins.state.pa.us

Rhode Island
1511 Pontiac Avenue
Cranston, RI 02920
(401) 462-9500
http://www.dbr.state.ri.us

South Carolina
PO Box 100105
Columbia, SC 29202
(803) 737-6160
www.doi.sc.gov

South Dakota
445 East Capitol Avenue
Pierre, SD 57501
(605) 773-3563
www.dlr.sd.gov/insurance/default.aspx

Tennessee
500 James Robertson Pkwy.
Nashville, TN 37243
(615) 741-2176
www.tn.gov/commerce/insurance

Texas
PO Box 149104
Austin, TX 78714
(800) 252-3439
www.tdi.texas.gov

Utah
450 N State Street, STE 3110
Salt Lake City, UT 84114
(800) 439-3805
www.insurance.utah.gov

Vermont
89 Main Street
Montpelier, VT 05620
(802) 828-3301
www.dfr.vermont.gov

Virginia
PO Box 1157
Richmond, VA 23218
(800) 552-7945
www.scc.virginia.gov/boi

Washington
PO Box 40256
Olympia, WA 98504
(800) 562-6900
www.insurance.wa.gov

West Virginia
PO Box 50540
Charleston, WV 25305
(888) 879-9842
www.wvinsurance.gov

Wisconsin
PO Box 7873
Madison, WI 53707
(800) 236-8517
www.oci.wi.gov

Wyoming
106 East 6th Avenue
Cheyenne, WY 82002
(800) 438-5768
www.insurance.state.wy.us

The issuance of this notice 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 with respect to the insurance.

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.

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 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 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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject 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.

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.