Cigna
P.O. Box 9060
Phoenix, AZ 85068-9060

Group/Association - Proof of Loss
Hospital Indemnity Insurance

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

500466b Rev. 12/2014

Group / Association – Proof of Loss
Hospital Indemnity Insurance

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 FORM

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.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR IN-HOSPITAL BENEFITS ONLY.

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
B. Have the reverse side of the form completed and signed by the Attending Physician.
C. Return the fully completed form and the **itemized hospital bill** to you 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 assigned Claim Office.

TO BE COMPLETED BY THE INSURED / EMPLOYER

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	DATE OF LAST CHANGE IN BENEFIT

AMOUNT OF INSURANCE	DATE HIRED/MEMBER OF ASSOCIATION	EFFECTIVE DATE OF INSURANCE	PREMIUM PAID THROUGH DATE

WAS THE ABOVE CONSIDERED AN EMPLOYEE/ASSOCIATION MEMBER UNTIL DATE OF HOSPITALIZATION? IF NOT, PLEASE EXPLAIN.	WAS COVERAGE STILL IN EFFECT AT THE TIME OF HOSPITALIZATION? IF NOT, PLEASE EXPLAIN.

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER/ASSOCIATION	DIVISION

ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)	TELEPHONE # ( )

I TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT	SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED

Group / Association – Proof of Loss
Hospital Indemnity Insurance

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

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR IN-HOSPITAL BENEFITS ONLY.

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To the Employee/ Insured/Association Member:

A. Complete the Employee/Insured/Association Member section of this form
B. Have the reverse side of the form completed and signed by the Attending Physician.
C. Return the fully completed form and the **itemized hospital bill** to you 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 assigned Claim Office.

TO BE COMPLETED BY THE EMPLOYEE / INSURED / ASSOCIATION MEMBER

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 # ( )

PATIENT LAST NAME, FIRST NAME, MIDDLE INITIAL (IF NOT EMPLOYEE/ASSOCIATION MEMBER)

OCCURRENCE OF ILLNESS OR INJURY Date Time	DATES OF CONFINEMENT From To	NAME AND ADDRESS OF HOSPITAL

IF INJURED, DESCRIBE FULLY HOW AND WHERE ACCIDENT OCCURRED.

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE HOSPITALIZED PERSON DURING THE PAST 2 YEARS.

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

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/ASSOCIATION MEMBER	DEPENDENT'S OCCUPATION	AMOUNT OF DEPENDENT INSURANCE

COMPLETE IF CLAIM IS FOR DEPENDENT CHILD
☐ Full Time Student
☐ Part Time Student

NAME & ADDRESS OF SCHOOL

PAYMENT AUTHORIZATION —
I AUTHORIZE PAYMENT OF ALL BENEFITS TO THE NAMED HOSPITAL ☐ Yes ☐ No

IF YES, SIGNATURE OF EMPLOYEE/ASSOCIATION MEMBER

DATE SIGNED

I CERTIFY THAT THE FORGOING INFORMATION IS TRUE AND CORRECT

SIGNATURE OF EMPLOYEE/ASSOCIATION MEMBER

DATE SIGNED

Disclosure Authorization

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.

CLICK TO PRINT

PHYSICIAN'S CERTIFICATE

PATIENT'S NAME

DIAGNOSIS AND CONCURRENT CONDITIONS (IF FRACTURE OR DISLOCATION, DESCRIBE NATURE AND LOCATION)

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF YES, STATE WHEN AND DESCRIBE. ☐ Yes ☐ No

NATURE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE FULLY) ☐ Inpatient ☐ Outpatient Date Performed _____

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No

REMARKS

PRINT PHYSICIAN'S NAME	DEGREE	TAX I.D. NUMBER
STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE		TELEPHONE NUMBER
PHYSICIAN'S SIGNATURE		DATE SIGNED

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 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.

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.