Cigna Group Universal Life and Group Variable Universal Life Insurance Claim Form

Important Instructions

GENERAL INFORMATION

1. Please have each beneficiary submit his or her own claim statement.

2. Along with this completed claim form, please include a copy of the insured's Death Certificate.

SECTION 2 - BENEFICIARY INFORMATION

1. Please be sure to describe in what capacity you are making this insurance claim. For example, you may be legally entitled to receive the insurance proceeds because you are the **beneficiary** of the policy, the **guardian of the estate** of the beneficiary, the **assignee** who was assigned the proceeds of this policy, **executor** or the **administrator** of the insured's estate, or the trustee for this policy. Simply list the appropriate term or describe your relationship to the insured in this section.

2. For the following special situations, please note that you will need to provide some additional information.

   a) *If the beneficiary is not of legal age,* please note that a Guardian of the beneficiary's estate must be appointed. The Guardian must then complete the claim form. A copy of the appointment certificate must also be sent in with the claim form.

   b) *If the insurance is payable to the insured's estate,* an Administrator or Executor must be appointed. The Administrator or Executor must then complete the claim form. A copy of the appointment certificate must be sent in with the claim form.

   c) *If the insurance is payable to a trust,* please provide a copy of the Trust Agreement. The Trustee must then complete the claim form.

SECTIONS 3 AND 4 - CLAIMS FOR DEPENDENT BENEFITS AND ACCIDENT DEATH BENEFITS

You will need to complete Section 3 only if you are claiming Dependent Benefits. You will need to complete Section 4 only if you are claiming Accidental Death Benefits.

IMPORTANT REMINDERS

1. Please review all your answers carefully to make sure they are accurate and complete. Then sign and date the form, and return it with all the necessary additional documents in the enclosed prepaid envelope.

   Claim Department
   Cigna
   P.O. Box 22328
   Pittsburgh, PA 15222-0328

2. Please understand that for the protection of the policy's beneficiaries, Cigna reserves the right to require or obtain additional information.

Life Insurance Claim Statement

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.***

So that we can process your claim as quickly and efficiently as possible, we ask that you supply the following information about yourself and the Insured. If you have any questions about how to complete this form, please call our Claim Service Center at 1-800-238-2125.

1. INFORMATION ABOUT THE INSURED

INSURED'S NAME | DATE OF BIRTH | ☐ Male ☐ Female

ADDRESS | CITY/STATE/ZIP

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

SOCIAL SECURITY # | POLICY # | CERTIFICATE #

INSURED'S EMPLOYER | EMPLOYER PHONE #

Please list any hospitals, clinics or physicians that treated the deceased during the past three years:

NAME | HOSPITAL/PHYSICIAN PHONE #

ADDRESS | CITY/STATE/ZIP

NAME | HOSPITAL/PHYSICIAN PHONE #

ADDRESS | CITY/STATE/ZIP

2. BENEFICIARY INFORMATION

BENEFICIARY'S NAME | DATE OF BIRTH | ☐ Male ☐ Female

ADDRESS | CITY/STATE/ZIP

TELEPHONE # | SOCIAL SECURITY #

If the Estate is the Beneficiary, has an Administrator or Executor been appointed or to be appointed? ☐ Yes ☐ No

If Yes, please provide a copy of the appointment certificate with the claim documents or when available.

3. IF CLAIM IS FOR DEPENDENT BENEFITS

DEPENDENT'S NAME | DATE OF BIRTH | ☐ Male ☐ Female

RELATIONSHIP TO INSURED | DEPENDENT'S SOCIAL SECURITY # | DEPENDENT'S OCCUPATION

DEPENDENT'S EMPLOYER | DEPENDENT'S LAST DAY WORKED | DEPENDENT'S EMPLOYER TELEPHONE NUMBER

If child, ☐ Full-time student ☐ Part-time student

Name and address of school: _____

School Telephone No.: _____ Is this your last eligible dependent child? ☐ Yes ☐ No

4. IF CLAIM IS FOR ACCIDENTAL DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT, ENHANCED ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Please describe the Insured's accident. Include information on how it happened, as well as the date of the accident.

What diseases, illnesses or injuries did the deceased have during the past three years? _____

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

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.***

Deceased's Name: ⓘ _____ **Deceased's Date of Birth:** _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning the deceased's health condition, or health history, or regarding any advice, care or treatment provided to the deceased. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice of the deceased's physical or mental condition, or other information concerning the deceased which may be needed to determine policy claim benefits with respect to the deceased. This may also include (but is not limited to) information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. I understand that I may choose whether to receive the results of any laboratory tests or medical examinations performed. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Insured's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the deceased to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning the deceased's occupation, activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used by the Company to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the deceased. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be released to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If the medical information contains information regarding drug or alcohol abuse, I understand that the deceased's records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

I hereby represent that I am authorized to execute this Disclosure Authorization for the release of this information.

Signature of Claimant or
Claimant's Authorized Representative: _____ Date: _____

Relationship,
if other than Claimant: _____ Claimant's Date of Birth: _____

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 Company, New England Life Insurance Company, Alta Health & Life Insurance Company, Connecticut General Life Insurance Company.

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

Beneficiary: Please complete and return to the Employer or Cigna.

ELECTRONIC COMMUNICATIONS DISCLOSURE AND CONSENT

Please read this information carefully. Then, print and keep a copy for yourself.

As a valued Cigna customer, we send you information about your benefits through the mail. This information may include:

- Claim forms, authorizations, disclosures, affidavits, electronic funds transfer agreements, privacy notices, and letters letting you know about changes to any of these items;
- Claim status updates letting you know that we've received a claim, or that we've updated the status of a claim;
- Letters asking you, or someone else, for additional information to help with the review of a claim.

Did you know that you may also give us consent to send you this information electronically?

Cigna has an easy to use tool called **Secure Email** that allows us to communicate with you electronically. All you need is a computer, internet access, and a personal email address (called a Designated Email).

By giving us your permission, known as consent, you understand you may no longer receive information in paper form and you accept responsibility for promptly reviewing the Secure Emails you receive. This ensures you can take appropriate action so that any benefits you are eligible for are not delayed or that any rights you have are not affected.

What do I need to know before I give my consent?

Access to Paper Copies

At any time, you can still request paper copies of information. Simply email us from your valid Designated Email, call customer service or send us a letter by mail. We keep copies of the information we email for the time periods required by law. We recommend saving or printing copies of the information you get electronically to ensure you have it when you need it.

System Requirements

To use Secure Email, access messages, and keep copies of the information we send you must have a working, personal Designated Email address and a computing or communications device with:

- working Internet access,
- a Web browser that supports 128-bit encryption (such as Chrome®, Firefox®, Internet Explorer®, or Safari®),
- 16 MB of available memory (32 MB of RAM recommended) and
- a program that can view, save and print PDF files (such as Adobe® Reader® 4.0 or higher).

Our Right to Send Paper

We have the right to send you information through the mail even if you agreed to receive it electronically. For example, we may send you a letter through the mail if we have a system outage, if we suspect fraud, if for any reason your Designated Email does not accept emails from us, or if we receive notification that you have not opened your email messages in Secure Email.

Modification of Consent Terms

We reserve the right to modify (change) these terms and conditions if we choose. We will provide you with notice of a modification electronically, and the date it is to go into effect. If you do not agree to the new terms and conditions, you must notify us of your Withdrawal of Consent before the effective date. Failure to withdraw your consent, or follow the instructions in the notice, lets us know that you agree to the new terms.

Withdrawal of Consent

Your consent remains in effect until you tell us otherwise and provide a Withdrawal of Consent. You may withdraw your consent at any time if you decide you want to go back to paper information. To contact us, you may email using the same valid, personal e-mail address you used to register for Secure Email, call us at 1-800-238-2125, or send us a letter by mail. Withdrawing your consent will let us know that you want to stop receiving Secure Emails. It will not change the outcome of any information we have already sent you.

Beneficiary: Please review and keep for your records.

Your Consent

Please read the following paragraph, make your selection, print and sign your name, enter the date, give us your email address, and provide the employee's name and date of birth.

By signing my name below, I agree that I have read the information in this letter about Cigna's Secure Email tool and I wish to receive information electronically from Cigna. I also agree that:

1. I have technology that meets the System Requirements highlighted above,
2. I have received written instruction in this letter on how to receive and manage messages using Secure Email, and
3. I will provide and maintain a valid Designated Email and that this email belongs to me. I agree to maintain this email until I provide Cigna with a new one (if appropriate) by calling customer service or sending a letter through the mail.
4. I understand that Cigna will only send me information electronically from this point forward unless I withdraw my consent.

If Cigna does not receive your signed Consent, Cigna will continue to send paper communications. If you do not wish to receive information electronically from Cigna, do not sign or return this form to Cigna.

Select One:

☐ I consent to receive information electronically for ALL claims for which I am eligible for benefits.

☐ I consent to receive information electronically ONLY for the following type of claims for which I am eligible for benefits:

☐ Life ☐ Accidental Death

Name: _____ **Email Address:** _____
(Please print clearly) (Please print clearly)

Signature: _____ **Date:** _____

Name of Employee: _____ **Date of Birth:** _____

Beneficiary: Please complete and return to the Employer or Cigna if you wish to participate in electronic communications.
Do not complete or return this form to the Employer or Cigna if you do not wish to participate in electronic communications.

How to Use Cigna Secure Email

Here's how it works.

Cigna sends an email to a secure website where you login and retrieve it. The first time you receive a Secure Email, you need to login and register. Registration confirms your identity and is completed by following these simple instructions.

1. Open the Secure Email you receive and click on the enclosed link. This opens the registration page.
2. Enter your first, middle (optional) and last name in the space provided.
3. Enter a password and password reminder that you choose.
4. Select two security questions from the drop down menu and provide answers you can easily remember.
5. Click the **register** button. An email confirmation is sent to your personal email address we have on file.
6. Now, check your personal email inbox. Open the email titled **Secure Email Registration Confirmation** and click the link. Your account is now active!

After you have successfully registered for Secure Email, you are ready to read, reply, forward and create messages.

- To Read Messages in your Inbox: The Inbox page lists messages that you received within the last 60 days. You can read, reply, forward, download and delete messages in your Inbox. In addition, you may print any message and download attachments.

- To Create a Message: The Compose option is available so that you may reach out and contact Cigna. Please note that this feature is restricted to sending messages to Cigna employees only.

What if I forget my password?

If you forget your password, you may request a reminder from the login page (https://www.cignasecure.com). You need to know the personal email address you used when you registered for Secure Email.

Where can I get help?

The Cigna Customer Support Center provides support for the Secure Email tool. You can reach them at 800-284-8346 or at 856-346-5301.

Beneficiary: Please review and keep for your records.

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.