

**Group/Association - Proof of Loss  
Life Insurance  
Accidental Death Insurance**

Connecticut General Life Insurance Company  
Life Insurance Company of North America  
New York Life Group Insurance Company of NY



**GROUP BENEFIT  
SOLUTIONS**

MAIL TO:

**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, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.**

**INSTRUCTIONS FOR FILING A CLAIM**

THIS FORM IS FOR LIFE INSURANCE OR ACCIDENTAL DEATH PROCEEDS ONLY. COMPLETE THE FORM ACCORDING TO THE INSTRUCTIONS, TO AVOID DELAY OR RETURN OF THE FORM. **IN BOXES WHICH CONTAIN THE SYMBOL (i), ADDITIONAL INFORMATION IS PROVIDED WHEN HOVERING OVER THE FIELD TO BE COMPLETED. THIS FEATURE IS ONLY AVAILABLE ON THE FILLABLE VERSION OF THIS FORM.**

- To The Employer/Administrator:
1. If claiming employee death benefits, please complete Sections A and C. If claiming dependent spouse or child benefits, please complete Sections A, B, and C.
  2. If claiming voluntary or employee-paid benefits, please provide all of the enrollment history for the employee and the dependent (if claiming dependent benefits).
  3. Please have each beneficiary review pages 1 through 10 and complete the appropriate pages.
  4. Submit completed form to your assigned Claim Office with a Death Certificate, Beneficiary Designation and Enrollment Information, if applicable.

**SECTION A: EMPLOYEE INFORMATION**

<b>(i)</b> Name of Employee/Member (Last Name)	(First Name)	(Middle Initial)	Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Address (Street)	(City)	(State)	(Zip Code)
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Employee's/Member's Marital Status  
 Single    Married    Widow/Widower    Separated    Divorced    Domestic Partner Relationship    Civil Union

Policy Number(s): List all policies under which benefits are due.	Occupation	<b>(i)</b> Was insurance issued on the basis of a statement of physical condition? (If yes, attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No
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**(i)** Check all of the boxes that apply to the Employee/Member's employment/membership status and job classification.

<input type="checkbox"/> Active	<input type="checkbox"/> Exempt	<input type="checkbox"/> Management	<input type="checkbox"/> Supervisory	<input type="checkbox"/> Union Local # _____	<input type="checkbox"/> Salaried	Hrs./Wk. _____
<input type="checkbox"/> Retired	<input type="checkbox"/> Non-Exempt	<input type="checkbox"/> Non-Management	<input type="checkbox"/> Non-Supervisory	<input type="checkbox"/> Non-Union	<input type="checkbox"/> Hourly	<input type="checkbox"/> Full-time
					<input type="checkbox"/> Part-time	

<b>(i)</b> Basic Annual Earnings	<b>(i)</b> Effective Date of Earnings	<b>(i)</b> Employee's Division/Location	<b>(i)</b> Policy Class #
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<b>(i)</b> Amount of Insurance: <b>If claiming voluntary benefits, please provide enrollment information.</b> Basic: _____ <b>Life</b> Voluntary: _____ SIB: _____	<b>AD&amp;D (Please complete only if claiming AD&amp;D benefits):</b>	Basic: _____ Voluntary: _____ BTA: _____
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**(i)** Has voluntary coverage for the employee/dependent been in effect continuously since enrollment?    Yes    No  
 If No, please include enrollment history and enrollment forms if not already provided.

<b>(i)</b> Date Hired/Member of Assoc.	<b>(i)</b> Effective Date of Insurance	<b>(i)</b> Date Last Worked	Date of Death	<b>(i)</b> Premium Paid Through Date	<b>(i)</b> Has an assignment been taken? (If yes, attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Was the above Considered an Employee/Association Member until his/her Date of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, Please Explain</i>	<b>(i)</b> Was the Employee actively at work until the date of the Dependent's death? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, indicate reason below.</i>
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**(i)** If the Employee was not actively at work immediately prior to his/her death or Dependent's death, what was the reason?

<input type="checkbox"/> Disability (STD)	<input type="checkbox"/> Paid Leave of Absence	<input type="checkbox"/> FMLA	<input type="checkbox"/> Temporary Layoff	<input type="checkbox"/> Resigned	<input type="checkbox"/> Minnesota Continuation (Please attach COBRA form.)
<input type="checkbox"/> Disability (LTD)	<input type="checkbox"/> Unpaid Leave of Absence	<input type="checkbox"/> Vacation	<input type="checkbox"/> Sabbatical	<input type="checkbox"/> Discharged	<input type="checkbox"/> Other: _____

Was coverage still in effect through the Date of Death? <i>If No, Please Explain</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>(i)</b> Is there a Beneficiary Designation on file for this Employee/Member? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please provide the most recent beneficiary designation with the claim.</b>
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Did the Employee have health care coverage with Cigna?    Yes    No

**Beneficiary: please review and keep for your records.**

**SECTION B: DEPENDENT SPOUSE OR DEPENDENT CHILD INFORMATION**

Name of Dependent ( <i>Last Name</i> )		( <i>First Name</i> )		( <i>Middle Initial</i> )		Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Relationship to Employee/Association Member	Amount of Dependent Insurance <b>Life</b> Basic: _____ Voluntary: _____ <b>AD&amp;D</b> Basic: _____ Voluntary: _____					Dependent's Occupation		
Was the Dependent Totally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date Disability Began		Dependent's Last Day Worked		Date of Marriage			
Dependent's Employer			Dependent's Employer's Telephone Number			Is Child <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student		
Name & Address of School ( <i>Street</i> )			( <i>City</i> )		( <i>State</i> )		( <i>Zip Code</i> )	
								School Telephone Number

**SECTION C: EMPLOYER'S/ADMINISTRATOR'S CERTIFICATION**

Name of Employer/Association			Email Address		
Address ( <i>Street</i> )		<i>City</i>		<i>(State)</i> ( <i>Zip</i> )	
			Telephone Number		
This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.					
Signature		Title		Date	

**SECTION D: ACCIDENTAL DEATH INFORMATION**

① Where and How Did the Accident Happen? Please Describe in Detail		Date and Time of Accident

**SECTION E: BENEFICIARY INFORMATION**

① Name of Beneficiary ( <i>Last Name</i> )		( <i>First Name</i> )		( <i>Middle Initial</i> )		Date of Birth	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address ( <i>Street</i> )			<i>(City)</i>		<i>(State)</i> ( <i>Zip Code</i> )		Relationship to Deceased	Daytime Telephone No.
Email Address								
Name and Address of Legal Guardian if Beneficiary is A Minor <i>If guardianship of the minor's estate has been established, please attach court order.</i>								
Did the Deceased convert or port his/her life insurance coverage prior to his/her death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If claiming voluntary life or basic and/or voluntary AD&D benefits, please list all hospital, clinics or physicians that treated the deceased within the past 5 years.								
<b>Name</b>		<b>Phone Number</b>		<b>Complete Address</b>			<b>Treatment Period</b>	
<b>I certify that the foregoing information is true, correct and complete to the best of my knowledge.</b>								
Beneficiary Signature							Date	

# Disclosure Authorization



GROUP BENEFIT  
SOLUTIONS

Life Insurance Company of North America  
Connecticut General Life Insurance Company  
New York Life Group Insurance Company of NY

**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" refers to: Life Insurance Company of North America  
Connecticut General Life Insurance Company  
New York Life Group Insurance Company of NY

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## 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.

**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.

**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 Residents:** 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 includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

**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.

**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.

**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.

**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.

**Beneficiary: Please review and keep for your records.**