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

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

CIGNA Group Insurance
Life • Accident • Disability

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

LMS-613500 Rev. 06/2011

Clear Fields

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 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 ⓘ, 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:
A. Submit completed form to your assigned Claim Office with a certified Death Certificate and Beneficiary Designation.
B. If claiming voluntary or employee-paid benefits, include enrollment information for the current year and the previous two years (if available).

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

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

Address *(Street) (City) (State) (Zip Code)*

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. **FLX965530, OK967109** | Occupation | ⓘ Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

ⓘ Check all of the boxes that apply to the Employee/Member's employment/membership 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 | ⓘ Policy Class #

ⓘ Amount of Insurance: If claiming voluntary benefits, please provide enrollment information.
Life Basic: Voluntary: SIB:
AD&D *(Please complete only if claiming AD&D benefits):* Basic: Voluntary: BTA:

ⓘ Date Hired/Member of Assoc. | ⓘ Effective Date of Insurance | ⓘ Date Last Worked | Date of Death | ⓘ Premium Paid Through Date | ⓘ Has an assignment been taken? *(If yes, attach copy)* ☐ Yes ☐ No

Was the above Considered an Employee/Association Member until his/her Date of Death? ☐ Yes ☐ No *If No, Please Explain*

ⓘ Was the Employee actively at work until the date of the Dependent's death? ☐ Yes ☐ No *If No, indicate reason below.*

ⓘ If the Employee was not actively at work immediately prior to his/her death or Dependent's death, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Minnesota Continuation *(Please attach COBRA form.)*
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged ☐ Other: _____

ⓘ Was coverage still in effect through the Date of Death? ☐ Yes ☐ No *If No, Please Explain*

ⓘ Is there a Beneficiary Designation on file for this Employee/Member? ☐ Yes ☐ No *Please provide the most recent beneficiary designation with the claim.*

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 | Amount of Dependent Insurance **Life** Basic: _____ Voluntary: _____ **AD&D** Basic: _____ Voluntary: _____ | Dependent's Occupation

Was the Dependent Totally Disabled? ☐ Yes ☐ No | If yes, Date Disability Began | Dependent's Last Day Worked

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 **Los Angeles Community College District** | Email Address

Address *(Street) City (State) (Zip)* | 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

TO BE COMPLETED IF CLAIM IS FOR ACCIDENTAL DEATH BENEFITS

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

SECTION TO BE COMPLETED BY THE BENEFICIARY

ⓘ Name of Beneficiary *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F

Mailing Address *(Street)* *(City)* *(State)* *(Zip Code)*	Relationship to Deceased	Daytime Telephone No.

Email Address

Name and Address of Legal Guardian if Beneficiary is A Minor *If guardianship of the minor's estate has been established, please attach court order.*

Did the Deceased convert or port his/her life insurance coverage prior to his/her death? ☐ Yes ☐ 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.

Name	Phone Number	Complete Address	Treatment Period

I certify that the foregoing information is true, correct and complete to the best of my knowledge.

Beneficiary Signature _____ Date _____

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 safe, secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts will be mailed to you, once your claim has been approved. You can take all or part of the money out of the account simply by writing a draft. You may write an unlimited number of drafts, in any amount, at any time. Any amount that remains in the account will continue to earn interest at competitive rates. Both your principal and any interest you earn are guaranteed by the insurance company. You will receive a quarterly statement for your CIGNAssurance® account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. Drafts are cleared through a draft account at State Street Bank. This account is not insured by the Federal Deposit Insurance Corporation or any federal agency. Account balances are the liability of the insurance company and 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.

I understand that if my benefit is at least $5,000, I will receive a CIGNAssurance® Account. If I wish to receive my proceeds as a lump sum payment, I may simply write a draft for the total amount of the account.

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

CIGNA Group Insurance
Life • Accident • Disability

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

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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).

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.

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.