State of Florida Account
Participating Agencies and Departments
Payroll Deduction Code 262

Mail To: **Cigna**
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free
Claims administered by Cigna

Group Life Insurance
Total and Permanent Disability / Waiver of Premium
Claim Form

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

816175 10/2013

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.***

SECTION TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

Name of Employee *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F
Address *(Street)* *(City)* *(State)* *(Zip Code)*		Telephone # ( )	

Insured's Marital Status ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced	Occupation *(Please attach a copy of the employee's Job Description)*	Was insurance issued on the basis of a statement of physical condition? ☐ Yes ☐ No *(If yes, attach copy)*

Please check the appropriate blocks regarding the insured's employment status.

☐ Active ☐ Retired ☐ Salaried ☐ Hourly Hrs./Wk. _____ ☐ Full-time ☐ Part-time

Basic Annual Earnings	Date Hired	Date of Last Change in Earnings	Date of Last Increase in Benefits
Date Last Worked	Number of Hours Worked	Effective Date of Insurance	Premium Paid Through Date
Percentage of Employee Contribution Towards Premium **100** %		Employee's Contribution were made on ☐ Pre-Tax or ☒ Post-Tax Basis	
Group Policy No.	Amount of Insurance		

Has Employee's / Member's Coverage Terminated? **DATE(S)** **REASON**

☐ Yes ☐ No

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

Name of Employer **STATE OF FLORIDA**	Department / Agency	E-Mail Address
Address *(Street)* *(City)* *(State)* *(Zip Code)*		Telephone # ( )

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature of Authorized Representative | Date Signed

TO BE COMPLETED BY THE EMPLOYEE

Date of Accident or Beginning of Sickness	E-Mail Address	Did you apply for conversion of your Group Policy? ☐ Yes ☐ No If "yes", please provide policy number and effective date:

Name other sources of income to which you and your dependents are entitled by checking the appropriate sources listed below. Please indicate below the current status of Social Security Disability/Retirement benefit (check appropriate status). If you are receiving Social Security benefits, please provide us with a copy of the most recent decision (Award or Denial).

☐ Social Security

☐ Awarded ☐ Denied/No appeal has been filed ☐ Denied/Filed for Reconsideration ☐ Denied/At Administrative Law Judge Level

☐ Other (Comments) _____

☐ Pension ☐ Worker's Compensation _____ (Identify Insurance Carrier) _____ (Policy Number)

☐ Governmental

☐ Disability Insurance _____ (Identify Insurance Carrier) _____ (Policy Number)

Describe in your own words what is wrong with you. (If accident, describe circumstances)

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY THE EMPLOYEE *(Continued)*

EDUCATION

Level of Education Completed: (circle one)
1 2 3 4 5 6 7 8 9 10 11 12

High School Diploma ☐ Yes ☐ No

G.E.D. ☐ Yes ☐ No

Vocational, Business or Correspondence School (name, address, courses)

Name: _____ Name: _____

Address: _____ Address: _____

Courses: _____ Courses: _____

Certificates or Special Licenses: _____

College Education Completed: (circle one) 1 2 3 4 5 6	Major(s)	Degree(s)

U.S. Military or Naval Science ☐ Yes ☐ No	If Yes, Special Training

WORK HISTORY

Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary
Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary
Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary

MEDICAL HISTORY

Please list any hospitals, clinics or physicians that treated you during the last 3 years. (Attach a separate sheet of paper, if needed)

Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No

Are you able to take care of all your personal care needs (grooming, dressing, etc.). If no, what areas require assistance?

Please indicate the chores you perform on a regular basis (check all that apply)

☐ Cooking ☐ Shopping ☐ Laundry ☐ Cleaning ☐ Child Care ☐ Yard Work, Gardening ☐ Other _____

Do you go for walks? ☐ Yes ☐ No If yes, how often and how far to you walk? _____

EMPLOYEE'S CERTIFICATION

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature of Employee	Date Signed

The issuance of this blank 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 in the premises.

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

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

Group Life Claim Form Waiver of Premium

PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

Please complete all relevant sections as thoroughly as possible and include medical documentation to support your findings.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED

NAME			EMPLOYER NAME
ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	GROUP POLICY NUMBER
TELEPHONE	OCCUPATION		DATE OF BIRTH

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1. DIAGNOSIS (Including any complications)

(a) Diagnosis (Include ICD-9 or DSM IV-TR Code)

(b) Subjective symptoms

(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)

(d) Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain

(e) Is illness work related? ☐ Yes ☐ No

(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____

2. DATES OF TREATMENT

(a) Date patient first visited you for this accident/illness: *Month Day Year*

(b) Date patient first unable to work due to this accident/illness: *Month Day Year*

(c) List frequency & date(s) patient was examined for this accident/illness:

(d) Date of last visit: *Month Day Year*

3. NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)

(a) Hospitalization on: *Month Day Year* **THROUGH** *Month Day Year*

(b) Surgery on: *Month Day Year* Type of Surgery:

(c) Name and Address of Hospital

(d) **Medications**	**Type**	**Dosage**

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8-hour work day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently
Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** = 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

Axis II: _____

Axis III: _____

AxisIV: _____

Axis V: Current GAF: _____ Highest GAF in past year: _____ Baseline: _____

Additional Comments:

6. RETURN TO WORK STATUS	**PATIENT'S REGULAR OCCUPATION**	**ANY OTHER OCCUPATION**
When was patient able to go to work?	☐ Full-time ☐ Part-time ____ / ____ / ____ (Mo. / Day / Yr.)	☐ Full-time ☐ Part-time ____ / ____ / ____ (Mo. / Day / Yr.)

7. REMARKS

Physician Name *(Please Print)* :	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( )	Federal Tax ID #:
Physician Signature:	Date:

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.

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

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.