Group Long Term Disability - Conversion

MAIL OR FAX TO: Cigna
PO Box 709015
Dallas, TX 75370-9015
Facsimile (800) 642-8553

CLEAR FORM

ICU
P O Box 20187
Lehigh Valley, PA 18002-0187

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.

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, Rhode Island, Tennessee, Texas, Virginia or Washington.***

TO BE COMPLETED BY THE EMPLOYEE

PLEASE TYPE OR PRINT - BE SURE TO ANSWER ALL QUESTIONS AND SUBMIT A FULLY COMPLETED ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY - FAILURE TO DO SO MAY DELAY YOUR CLAIM

1. NAME (*Last, First, M.I.*)	SOCIAL SECURITY NO.	SEX ☐ M ☐ F	DATE OF BIRTH

2. ADDRESS *(where you may be reached during the next six months)*	ZIP CODE	TELEPHONE NO. *(Include Area Code)*	CURRENT POLICY NO.

3. NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH	IS SPOUSE EMPLOYED? IF YES, IS SPOUSE ☐ Yes ☐ No ☐ Full Time ☐ Part Time

4. Do you have any children under age 18? ☐ Yes ☐ No	Do you have any children age 18-19, who are full-time students in elementary or secondary schools? ☐ Yes ☐ No	Do you have any handicapped children *(regardless of age)*? ☐ Yes ☐ No

If you answered yes to any of the above questions, please list names and dates of birth.

Name	Date of Birth

5. Date of accident or beginning of sickness:	Date you became totally disabled:	Date you plan to return to work:

6. Were you employed immediately prior to the date you became disabled? ☐ Yes ☐ No

Name of Employer: _____ Phone No. *(include area code)* _____

Address: _____

7. NAMES OF ATTENDING PHYSICIANS	ADDRESS	DATE FIRST CONSULTED

8. NAMES OF HOSPITALS	ADDRESS	DATE ENTERED HOSPITAL	DATE DISCHARGED

9. Have you applied for Social Security Benefits? ☐ Yes ☐ No If yes, please attach a copy of your Social Security application and/or a copy of the award certificate(s) for you and your dependent(s) or a copy of the Social Security denial letter.

Are you a Veteran? ☐ Yes ☐ No If yes, have you applied for VA benefits for this disability? ☐ Yes ☐ No
Please attach a copy of your VA Disability Award.

Are you receiving or eligible to receive:	Yes	No	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THROUGH DATE
Salary Continuance?	☐	☐	$ _____	/ /	/ /
Short Term Disability Income or Sick Pay?	☐	☐	$ _____	/ /	/ /
State Disability?	☐	☐	$ _____	/ /	/ /
Group Long Term Disability Income?	☐	☐	$ _____	/ /	/ /
Workers' Compensation?	☐	☐	$ _____	/ /	/ /
Pension Benefits?	☐	☐	$ _____	/ /	/ /
Any other Disability Income? *(Please identify)*	☐	☐	$ _____	/ /	/ /

10. I certify that the foregoing information is true and correct.

CLAIMANT'S SIGNATURE: _____ **DATE:** _____

11. Describe in your own words what prevents you from working.

12. Has your doctor given you special instructions about exercise, rest or diet? ☐ Yes ☐ No
If yes, please describe.

13. Describe what you do during a normal day.

14. Please indicate any hobbies or interests you had or still have.

15. Circle last grade completed: 1 2 3 4 5 6 7 8 9 10 11 12
College: 1 2 3 4 Masters PhD
If advanced or technical schooling, please indicate type of specialty.

16.

Name of Former Employer(s)	Dates Employed		Position & Duties	Salary
	From	Through		

17. Are you interested in seeking rehabilitation to some other line of work? ☐ Yes ☐ No

18. Have you contacted your State Department of Vocational Rehabilitation? ☐ Yes ☐ No
If yes, please provide the name of your counselor and the address of the office.

19. List states in which you may be liable for filing tax returns.

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; any of your social security disability advocates or representatives; 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, and/or 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.

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.

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.