Cancer Proof of Loss

CIGNA Group Insurance
Life • Accident • Disability

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

500463b (09/2007)

Cancer Proof of Loss

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

CIGNA

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 reverse side of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR CANCER BENEFITS ONLY.
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To the Employee/ Association Member:
A. Complete the Employee / Association Member section of this form
B. Have the reverse side of the form completed and signed by the Attending Physician/Provider.
C. Return the fully completed form, **itemized bills and a pathology report confirming the diagnosis** to your Employer / Administrator who will submit the form to the assigned Claim Office.

To the Employer/ Administrator:
A. Give the form to the Employee / Association Member for completion as indicated above.
B. Complete Employer's / Administrator's section.
C. Submit completed form to the assigned Claim Office.

TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

NAME OF EMPLOYEE/ASSOCIATION MEMBER (Last Name) (First Name) (Middle Initial)	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX ☐ M ☐ F
ADDRESS (Street) (City) (State) (Zip Code)		TELEPHONE # ( )	

POLICY NO.	CERTIFICATE NO.	OCCUPATION	DATE OF LAST CHANGE IN BENEFIT
AMOUNT OF INSURANCE	DATE HIRED/MEMBER OF ASSOCIATION	EFFECTIVE DATE OF INSURANCE	PREMIUM PAID THROUGH DATE

WAS THE ABOVE CONSIDERED AN EMPLOYEE/ASSOCIATION MEMBER UNTIL DATE OF HOSPITALIZATION? IF NOT, PLEASE EXPLAIN.	WAS COVERAGE STILL IN EFFECT AT THE TIME OF HOSPITALIZATION? IF NOT, PLEASE EXPLAIN.

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	DEPENDENT'S OCCUPATION	AMOUNT OF DEPENDENT INSURANCE	
COMPLETE IF CLAIM IS FOR DEPENDENT CHILD ☐ Full Time Student ☐ Part Time Student	NAME & ADDRESS OF SCHOOL		

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER / ASSOCIATION	DIVISION
ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE # ( )

I TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT	SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED

TO BE COMPLETED BY THE EMPLOYEE/ASSOCIATION MEMBER

OCCURRENCE OF ILLNESS OR INJURY Date Time	DATES OF CONFINEMENT From To	NAME AND ADDRESS OF HOSPITAL

IF INJURED, DESCRIBE FULLY HOW AND WHERE ACCIDENT OCCURRED.

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE HOSPITALIZED PERSON DURING THE PAST 2 YEARS.

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

PAYMENT AUTHORIZATION — I authorize payment directly to those physicians or providers described below, and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me.

IF YES, SIGNATURE OF EMPLOYEE/ASSOCIATION MEMBER: | DATE SIGNED

I CERTIFY THAT THE FORGOING INFORMATION IS TRUE AND CORRECT	SIGNATURE OF EMPLOYEE/ASSOCIATION MEMBER	DATE SIGNED

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): ______________________________

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 provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. 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. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. 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, Claimant'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 me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my 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 to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. 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 disclosed 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 or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; 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 my medical information contains information regarding drug or alcohol abuse, I understand that my 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 Social Security Number: ______________

Company Name: ______________________________

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.

TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA *USED, GIVE NAME)

REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED ONLY SHOW DATES AND SERVICES SINCE FIRST REPORT.)

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	PROCEDURE CODE - IS USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES

DO — DOCTOR'S OFFICE
PH — PATIENT'[S HOME
IH — INPATIENT HOSPITAL
OH — OUTPATIENT HOSPITAL
NH — NURSING HOME
OL — OTHER LOCATIONS

TOTAL CHARGES $ ______
AMOUNT PAID $ ______
BALANCE DUE $ ______

HAS INSURED EVER RECEIVED MEDICAL TREATMENT FOR ANY TYPE OF CANCER? ☐ **YES** ☐ **NO** If yes, what date?

DATE SYMPTOMS FIRST APPEARED

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

IS PATIENT STILL UNDER YOUR CARE? ☐ **YES** ☐ **NO**

NAME AND ADDRESS OF REFERRING PHYSICIAN

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ **YES** ☐ **NO**
If yes, when and describe

WHERE REGISTERED PRIVATE DUTY NURSE (R.N.) SERVICES NECESSARY? ☐ **YES** ☐ **NO**
If yes, from: to:

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TAX ID#

ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	TELEPHONE NO.

PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT CONFIRMING DIAGNOSIS.

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.

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 a 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 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 fact material thereto, may be committing a fraudulent insurance act.

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.

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.

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 my be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with 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.