

How to report a Disability Claim

Under Your Company's Group Disability Insurance Plan



It's easy! Call Cigna's toll-free number and a representative will walk you through the process. We will take all the information over the phone. Call: **1-800-36-Cigna** or **1-800-362-4462**. For Spanish-speaking customers, call **1-866-562-8421**. You can also fill out the online form on Cigna.com.

When do I report a claim?

- Always seek appropriate medical attention immediately. Your health and safety come first.
- Contact your employer on or before your first day out of work. Tell them when and how long you expect to be absent.
- When you know you will be out for more than seven days in a row, contact Cigna at the phone number above. Please contact us no later than your seventh day out of work, so we can begin reviewing your claim.

What information will I need to give?

Before you call or fill out the claim form, please make sure you can give us:

- Your name, address, phone number, birth date, Social Security number and e-mail address.
- Employment information, such as date hired and job title.
- The reason for your claim – illness, injury, or pregnancy.
- A description of your illness, symptoms, and/or diagnosis. Include the date the symptoms first appeared and if you have had these symptoms before.

 *Clip here and carry with you for easy reference.*

How to report a disability claim
1-800-36-Cigna (24462) or 1-866-562-8421 (Español)
Visit: Cigna.com

Please have this information ready before you call:

- Your name, address, phone number, birth date, date of hire, Social Security Number and your employer's name, address and phone number.
- The date and cause of your disability and when you plan to return to work. If you are pregnant, give your expected delivery date.
- The name, address and phone number of each doctor you are seeing for this absence.

*Insurance products and services are provided through
Life Insurance Company of North America.*

- Information about any workers' compensation claims you have filed or plan to file.
- Details about all doctor, hospital or clinic visits, including dates and contact information.

What happens next?

- During the phone call, we will ask you for your permission to get your medical information. You can do this during that same call. This will help to process your claim more quickly

Here's how it works.

- After you finish giving us your claim information, the phone agent will transfer you to a recorded message.
- Listen to the recording and answer "Yes" or "No" to the questions.
- At the end of the recording, say "Yes" if you give permission or "No" if you do not.

After the call, Cigna will send you a letter. This letter will include a copy of the recorded message for your records. The letter will also include a form for you to sign and return. This form gives us permission to get other information we may need to finish processing your claim. Please sign and return that form. Check with your doctor to see if he or she has any other forms you may need to sign to give permission to release medical records.

- You can cancel your recorded permission at any time by calling your Cigna claim manager.
- A Cigna claim manager will call you and your employer for a list of your job requirements. The claim manager will also call your doctor for your medical records. This information will help us figure out how long you may be out of work and the benefits you may be able to receive.

What happens if my claim is approved?

- If your claim is approved, Cigna will send you an approval letter that explains your benefits. You may also receive an automated call from Cigna with this information.
- We will coordinate payment of your benefits as soon as possible.
- We will also tell your employer that we approved your claim and the date you plan to return to work.

What happens if my claim is denied?

- If your claim is denied, Cigna will send you a letter that explains why. The letter will also tell you how you can appeal the decision.
- Cigna will let your employer know we denied the claim.
- Contact your employer when you receive the letter to discuss your return to work

What can I expect while I am out on disability?

Our goal is to help you return to work quickly and safely. That's why your Cigna claim manager will stay in touch with you. We may work with you, your physician and your employer to talk about different work options. This may include job adjustments or a work schedule change. Your employer may also call you to check on your progress and offer support.

What if I can't return to work when my disability benefits end?

- Call your Cigna claim manager to talk about the situation. Your claim manager will explain your options.
- Let your employer know your progress and status

What should I do when I'm ready to return to work?

Call your employer and Cigna claim manager to let them know the date you will return to work.

Have a Question?

Call **1-800-36-Cigna** (24462) between 7:00 a.m. and 7:00 p.m. Central Time. You can leave a message if you call at other times. A Cigna representative will return your call the next business day.

*Disability Coverage is underwritten by:
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192*

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Group/Association - Short Term Disability Benefits



CIGNA Group Insurance
Life • Accident • Disability

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

500385 Rev. 03/2012

**Group/Association -
Short Term Disability Benefits**

MAIL OR FAX TO: CIGNA Group Insurance
P.O. Box 709015
Dallas, TX 75370-9015
Facsimile: (800) 642-8553

CIGNA Group Insurance
Life • Accident • Disability

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

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 <input type="checkbox"/> M <input type="checkbox"/> F
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ADDRESS (Street)	(City)	(State)	(Zip Code)	TELEPHONE # ()
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POLICY NO.	OCCUPATION
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PLEASE CHECK THE APPROPRIATE BLOCKS REGARDING THE INSURED'S EMPLOYMENT STATUS.

<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"/> Full-Time
<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"/> Part-Time

BASIC EARNINGS PER WEEK	DATE OF LAST CHANGE IN EARNINGS	DATE HIRED / MEMBER OF ASSOCIATION	EFFECTIVE DATE OF INSURANCE
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WAS INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Attach Copy	EMPLOYEE'S / MEMBER'S CONTRIBUTIONS WERE MADE ON: <input type="checkbox"/> Pre-Tax Basis <input type="checkbox"/> Post-Tax Basis
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LAST DAY WORKED # of Hours: _____	DATE RETURNED TO WORK	PREMIUM PAID THROUGH DATE	% OF INSURED'S CONTRIBUTION TO PREMIUM
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IS THIS INDIVIDUAL COVERED UNDER A LIFE INSURANCE POLICY PROVIDED BY A CIGNA UNDERWRITING COMPANY? YES NO

IF YES, DOES THIS LIFE INSURANCE POLICY CONTAIN A WAIVER OF PREMIUM PROVISION? YES NO

PLEASE LIST ALL BENEFITS THAT THE INSURED IS RECEIVING OR ELIGIBLE TO RECEIVE AS A RESULT OF HIS/HER DISABILITY (E.G. SALARY CONTINUANCE, SICK PAY, STATE DISABILITY, WORKERS' COMPENSATION, ETC.).

BENEFIT	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THRU DATE

HAS EMPLOYEE/MEMBER BEEN LAID OFF? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE	REASON
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HAS EMPLOYEE/MEMBER BEEN TERMINATED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE	REASON
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EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER / ASSOCIATION	DIVISION
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ADDRESS (Street)	(City)	(State)	(Zip Code)	TELEPHONE # ()
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EMPLOYER / ASSOCIATION Print: _____	Signature: _____	Date: _____
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TO BE COMPLETED BY THE CLAIMANT

PLEASE TYPE OR PRINT BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM. USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY

DATE OF ACCIDENT OR BEGINNING OF SICKNESS	DATE FIRST UNABLE TO WORK	DATE YOU PLAN TO RETURN TO WORK	LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS
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DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, DESCRIBE CIRCUMSTANCES AND ADVISE WHETHER IT OCCURRED AT WORK).	HAVE YOU HAD THE SAME OR SIMILAR CONDITION IN THE PAST? IF SO, PLEASE DESCRIBE IN DETAIL.
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PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED YOU FOR YOUR ILLNESS OR INJURY. NAME	COMPLETE ADDRESS	TREATMENT PERIOD
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PLEASE DESCRIBE YOUR JOB DUTIES IN DETAIL. WHAT PERCENT OF YOUR JOB REQUIRES PHYSICAL LABOR?

PLEASE LIST ALL BENEFITS YOU ARE RECEIVING OR ELIGIBLE TO RECEIVE UNDER ANY OTHER GROUP INSURANCE, GOVERNMENT PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE. BENEFIT	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THRU DATE
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ARE YOU COVERED UNDER A LIFE INSURANCE POLICY PROVIDED BY A CIGNA UNDERWRITING COMPANY? YES NO
 IF YES, DOES THIS LIFE INSURANCE POLICY CONTAIN A WAIVER OF PREMIUM PROVISION? YES NO
 HAVE YOU ELECTED CIGNA HEALTHCARE MEDICAL INSURANCE THROUGH YOUR EMPLOYER? YES NO
 IF NOT, PLEASE PROVIDE THE NAME OF YOUR MEDICAL INSURANCE CARRIER _____

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED
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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.

TO BE COMPLETED BY ATTENDING PHYSICIAN

DIAGNOSIS AND CONCURRENT CONDITIONS, INCLUDING ICD-9 OR DSM IV-TR CODE.

IS CONDITION DUE TO PREGNANCY? Yes No IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION IF APPLICABLE.

APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT	DATE OF DELIVERY	TYPE OF DELIVERY
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COMPLICATIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.
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DATES OF SERVICE - INCLUDE DATE OF NEXT APPOINTMENT (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT).

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", WHEN AND DESCRIBE	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No
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HAS PATIENT BEEN HOSPITAL CONFINED? Yes No IF "YES", CONFINED FROM _____ THRU _____

NAME AND ADDRESS OF HOSPITAL _____

NATURE OF SURGICAL PROCEDURE, IF ANY _____

INPATIENT OUTPATIENT DATE PERFORMED _____

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED - (UNABLE TO WORK)

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

From: _____ Thru: _____

REMARKS: WE ARE INTERESTED IN ANY INFORMATION THAT WOULD BE HELPFUL TO YOUR PATIENT FOR EVALUATION OF THIS CLAIM.

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE
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DEGREE	SOCIAL SECURITY NUMBER	TAX IDENTIFICATION NUMBER
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STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	TELEPHONE
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Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability



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, 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.

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.