Notice of Claim

Return this claim form with itemized Hospital Facility Bill and Diagnosis Code or UB04 to:

CIGNA Health & Life Insurance Company (CHLIC)
(formerly known as "Alta Health & Life Insurance Company")
P.O. Box 2568
Jacksonville, Florida 32203-2568
Phone: 1.800.888.5256

☐ **30/20 PLAN** ☐ **365+ PLAN**

☐ **PPP PLAN** ☐ **SIS PLAN**

FOR OFFICE USE ONLY	
PLAN	
EFF. DATE	
PTD	

Instructions:

1. **Complete this "Notice of Claim" form by answering all questions and signing at the bottom of the form.**
2. **Mail the completed claim form to the address shown above, along with your ITEMIZED BILL (UB04).**

Please remember to:

- **Submit a separate claim form and Facility Bill for each Hospital Stay or Out Patient Surgery.**
- **Submit all claims within 15 months of Date of Service.**

EMPLOYEE'S STATEMENT

1. **Employee's Name** | Phone No: ( ) | Employee's Social Security No:

2. **Employee's Mailing Address** Street City State Zip Code

3. **Employee's Employment:**
   Department name _____
   Are your premium payments being made by: 1.) Payroll deduction ☐ 2.) Personal check ☐
   Are you a retired employee? Yes ☐ No ☐

4. **This claim is for:** Patient's Social Security No:
   ☐ Employee ☐ Child Name _____
   ☐ Spouse ☐ Stepchild Employee's date of birth / / Patient's date of birth / /

5. If stepchild, does this child reside with you? Yes ☐ No ☐

6. If patient is a child or stepchild over 19 years of age:
   Does this child reside with you? Yes ☐ No ☐
   Is this child wholly dependent on you for support and maintenance? Yes ☐ No ☐
   Does this child attend school as a full-time or part-time student? Yes ☐ No ☐
   If yes, name and address of school _____

7. Is this claim being filed under Workers' Compensation? Yes ☐ No ☐

8. Has employee's name changed since policy was issued? Yes ☐ No ☐
   If yes, give previous name _____

9. Name of Hospital _____
   Address _____
   Date of admission / / Phone ( ) _____

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution or employer to release information to CHLIC as is required to properly pay all benefits of this claim, if any, due me or my eligible family members.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

/ / **X** **X**

Date **Employee's Signature** **Patient's Signature (or if minor, parent)**