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

MAIL COMPLETED FORM TO:
Cigna
P.O. Box 22328
Pittsburgh, PA 15222-0328
Toll Free #: 1.800.238.2125
Fax #: 412.402.3506

State of Florida
Accelerated Benefits Claim Form

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

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.***

THIS FORM IS FOR ACCELERATED BENEFITS PROCEEDS ONLY, A FEATURE OF YOUR LIFE INSURANCE POLICY.
THIS CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.
To the Employer / Administrator: Complete the employer section of the form and deliver to the employee for submission to the assigned Claim Office.

TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR FOR EMPLOYEE AND DEPENDENT BENEFITS

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 ☐ DOMESTIC PARTNER RELATIONSHIP ☐ CIVIL UNION

POLICY NO.	DEPARTMENT/AGENCY	WAS INSURANCE ISSUED ON THE BASIS OF EVIDENCE ☐ Yes ☐ No

PLEASE CHECK THE APPROPRIATE BLOCKS REGARDING THE INSURED'S EMPLOYMENT STATUS. Hrs/wk

☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

BASIC ANNUAL EARNINGS	DATE OF LAST EARNINGS CHANGE	DATE OF LAST BENEFIT INCREASE	**FULL** FACE AMOUNT OF INSURANCE Basic: Voluntary:

DATE HIRED	EFFECTIVE DATE OF INSURANCE	LAST DATE WORKED	PREMIUM PAID THROUGH DATE

% OF INSURED'S CONTRIBUTION TO PREMIUM Basic: Voluntary: **100%**	INSURED'S CONTRIBUTION WERE MADE ON ☐ PRE-TAX OR ☒ POST TAX	HAS EMPLOYEE QUALIFIED FOR PREMIUM WAIVER ☐ Yes ☐ No	IF YES, AS OF WHAT DATE?

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	**FULL** FACE AMOUNT OF DEPENDENT INSURANCE POLICY Basic: Voluntary:	DEPENDENT'S OCCUPATION

EMPLOYER / ADMINISTRATOR'S CERTIFICATION

NAME OF EMPLOYER	DEPARTMENT/AGENCY	E-MAIL ADDRESS
State of Florida		

ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE #

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

SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE	DATE SIGNED

INSTRUCTIONS FOR FILING *(COMPLETE ALL INFORMATION)*

Important

Instructions for Employer:

- Please complete the sections on page 2 of this form.
- Please provide a copy of the beneficiary designation.
- If the employee has voluntary benefits, please provide proof of election or enrollment. (LINA, Alta, AH&L, Anthem, or Gulf Life)
- Please provide this form and copies of the enrollment forms and beneficiary designation to the employee for his/her completion and submission to the claim office.

Instructions for Employee:

- Please complete the sections on pages 3 and 4 of this form and review the Fraud Warning.
- You must indicate which benefit you are applying for and the percentage applied for. If unsure about what benefits are available in your plan, please check your employee benefits blooklet or plan or contact your human resources or benefits administrator.
- Please provide the requested information and dates regarding your condition.
- Be sure to provide the name, address, and telephone number of the Physician/s who has treated you or is familiar with your condition. The claim office will be writing to the Physician/s to confirm that you are eligible for benefits.
- Complete the requested information on your medical treatments within the past five years.
- Please sign the claim form.
- Please sign and date the authorization to release information.
- If you are unable to sign the claim form, someone else must sign for you, indicate their relationship to you, and provide written proof of their ability to legally sign for you.
- Please forward the fully completed form with copies of your enrollment forms and beneficiary designation to Cigna, P.O. Box 22328, Pittsburgh, PA 15222-0328.

BENEFIT INFORMATION - TO BE COMPLETED BY EMPLOYEE

BENEFIT APPLIED FOR	BENEFIT PERCENT APPLIED FOR **(If applicable)**	DATE DIAGNOSED	DATE OF FIRST TREATMENT
☐ Terminal Illness ☐ Specified Disease/ Critical Illness ☐ Nursing Care/ Custodial Care	Basic: _____% Voluntary: _____%		

DIAGNOSIS OR NATURE OF CONDITION

PLEASE PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF TWO (2) PHYSICIANS FAMILIAR WITH THE INSURED'S CONDITION.

NAME OF PHYSICIAN _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE NUMBER _____ FAX NUMBER _____

NAME OF PHYSICIAN _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE NUMBER _____ FAX NUMBER _____

NAME OF ANY OTHER PHYSICIANS, HOSPITALS, OR CLINICS TREATING WITHIN THE PAST FIVE YEARS (If applying for Terminal Illness, you must furnish one additional Physician Name)

NAME	**ADDRESS**	**TREATMENT PERIOD**

PORTABILITY/CONVERSION

HAVE YOU APPLIED FOR PORTABILITY? ☐ **YES** ☐ **NO** APPLICATION DATE: _____

HAVE YOU APPLIED FOR CONVERSION? ☐ **YES** ☐ **NO** APPLICATION DATE: _____

DO YOU HAVE HEALTH CARE COVERAGE WITH CIGNA? ☐ **YES** ☐ **NO**

HAVE YOU EVER BEEN PAID A TERMINAL ILLN ESS OR SPECIFIED DISEASE BENEFIT? ☐ **YES** ☐ **NO**

ARE YOU SUBJECT TO A QUALIFIED DOMESTIC RELATIONS ORDER? ☐ **YES** ☐ **NO**

ASSIGNMENT MADE/IRREVOCABLE BENEFICIARY DESIGNATED? ☐ **YES** ☐ **NO** If, yes, assignee/irrevocable beneficiary's signature required below giving permission for release of benefits to insured with the concurrence that such signature will release interest/rights to policy proceeds to insured.

SIGNATURE OF ASSIGNEE/IRREVOCABLE BENEFICIARY	DATE

I Certify that the Foregoing Statements are True, Correct and Complete

Signature of Claimant _____ Date _____

Note: The insurance carrier will report the amount of this distribution to the IRS on a Form 1099 LTC. The benefit may be TAXABLE INCOME. Your ability to receive certain government benefits/entitlements may be affected by receipt of this benefit. The insurance carrier recommends that you seek advice from a tax advisor and/or attorney if you have any questions about how the election of this benefit may affect your personal situation. Please remember that the face amount of the insurance policy will be reduced by any accelerated benefit amount paid. Premium payable will be calculated based on the full amount of the death benefit before any reductions were made due to the accelerated benefits paid.

Cignassurance® Program

If your insurance benefit is $5,000 or more, Cigna will automatically open a free, interest-bearing account in your name. This account, called the Cignassurance® Program, is a safe, secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts will be mailed to you, once your claim has been approved. You can take all or part of the money out of the account simply by writing a draft. You may write an unlimited number of drafts, in any amount, at any time. Any amount that remains in the account will continue to earn interest at competitive rates. Both your principal and any interest you earn are guaranteed by the insurance company. You will receive a quarterly statement for your Cignassurance® account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. Drafts are cleared through a draft account at State Street Bank. This account is not insured by the Federal Deposit Insurance Corporation or any federal agency. Account balances are the liability of the insurance company and the insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, Cigna will send you a check for the total benefit amount.

I understand that if my benefit is at least $5,000, I will receive a Cignassurance® Account. If I wish to receive my proceeds as a lump sum payment, I may simply write a draft for the total amount of the account.

_____ _____
Signature* Date

*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form 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.

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.