State of Florida Account
Participating Agencies and Departments
Payroll Deduction Code 0300

Mail To: **Cigna**
P.O. Box 16491
Pittsburgh, PA 15242-0791

Claims administered by Cigna

State of Florida
Group Long Term Disability Claim Form

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

State of Florida Account
Participating Agencies and Departments
Payroll Deduction Code 0300

Mail To: Cigna
P.O. Box 16491
Pittsburgh, PA 15242-0791

Claims administered by Cigna

Group Long Term Disability Initial Claim Submission Instructions

INSTRUCTIONS FOR EMPLOYEE:

- Page 3, Employee Statement: Answer all questions, date, and sign the form. Attach valid proof of your age, such as a copy of your Driver's License or Birth Certificate.
- Page 4, Disclosure Authorization Form: Read, sign, and date the authorization to release information form.
- Mail completed forms and proof of your age to: Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791.

ADDITIONAL INSTRUCTIONS FOR EMPLOYEE:

- Page 5, Employer/Administrator Statement: Complete lines 1 and 2 only, and forward the form to your Employer/ Administrator for completion.
- Page 6 and 7, Physician's Statement: Complete Patient/Insured section only, and forward to your Physician for completion.

INSTRUCTIONS FOR EMPLOYER/ADMINISTRATOR:

- Page 5, Employer/Administrator Statement: Answer all questions, sign and date the form.
- Attach a copy of the Employee's Job Description.
- Attach a copy of the Employee's Pre-Disability Payroll Statement.
- Mail completed form and supporting documents to: Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791.

INSTRUCTIONS FOR ATTENDING PHYSICIAN(S):

- Pages 6 and 7, Attending Physician's Statement: Answer all questions, sign and date the form.
- Mail completed form and supporting documents to: Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791.

Cigna®

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

State of Florida Group Long Term Disability Claim Form

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

EMPLOYEE INSTRUCTIONS:

- Answer all questions, date, and sign the form. Attach valid proof of your age, such as a copy of your Driver's License or Birth Certificate.
- Mail completed forms (Page 3 & 4) and proof of your age to: **Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791**.

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 EMPLOYEE

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

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

MAILING ADDRESS *(Address where you may be reached during the next six months)* *(City, State, Zip Code)*	PHONE NUMBER *(Include Area Code)*

Are you married, or do you have a domestic partner or civil union partner? ☐ Yes ☐ No
Do you have any children under age 25? ☐ 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 below.

NAME	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY NO.
1.		☐ M ☐ F		
2.		☐ M ☐ F		
3.		☐ M ☐ F		
4.		☐ M ☐ F		
5.		☐ M ☐ F		

LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS

DATE OF ACCIDENT OR BEGINNING OF SICKNESS	FIRST DATE YOU WERE UNABLE TO WORK	DATE YOU PLAN TO RETURN TO WORK

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, OR WORK-RELATED, DESCRIBE CIRCUMSTANCES)

NAMES OF ALL ATTENDING PHYSICIANS CONSULTED FOR THE DISABILITY	COMPLETE ADDRESS AND PHONE NUMBER	DATE FIRST CONSULTED

NAMES OF HOSPITALS	COMPLETE ADDRESS	DATE ENTERED-DATE DISCHARGED

Have you applied for Social Security Benefits? ☐ Yes ☐ No
If yes, please attach a copy of your Social Security notice for you and your dependents or a copy of your Social Security denial. If you have not applied, please do so as soon as possible. If you have not received a determination, please attach a copy of your receipt for application.

Are you receiving or eligible to receive:	$ Amount/Frequency	Date Began	Date Paid Thru
☐ Yes ☐ No Salary Continuance			
☐ Yes ☐ No State Disability Benefits			
☐ Yes ☐ No Group Disability Benefits			
☐ Yes ☐ No Workers' Compensation			
☐ Yes ☐ No Pension / Retirement Benefits			
☐ Yes ☐ No No-Fault Auto Disability Insurance (PIP)			
☐ Yes ☐ No Any other Disability Income (please identify)			
☐ Yes ☐ No Veterans' Benefits			

Are you covered under a life insurance policy provided by a LINA/Cigna underwriting company? (Payroll Deduction Code 0262) ☐ Yes ☐ No
If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE: **DATE:**

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.

State of Florida Group Long Term Disability Claim Form

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

EMPLOYEE INSTRUCTIONS:

- Complete lines 1 and 2 only, and forward the form to your Employer/Administrator for completion.

EMPLOYER/ADMINISTRATOR INSTRUCTIONS:

- Answer all remaining questions, sign, and date the form.
- Attach a copy of the Employee's Job Position Description and Pre-Disability Payroll Statement.
- Mail completed form and supporting documents to: **Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791.**

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (*Last, First, M.I.*)	SOCIAL SECURITY NO.	GROUP POLICY NUMBER **VDT2500** ___ ___
EMPLOYEE'S ADDRESS (City) (State) (Zip Code)		TELEPHONE NUMBER *(Include Area Code)*

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR

PLEASE COMPLETE IN FULL

DATE OF FULL TIME EMPLOYMENT	EFFECTIVE DATE OF EMPLOYEE'S LTD COVERAGE (PAYROLL DEDUCTION CODE 0300)	NAME OF DEPARTMENT/AGENCY	
BASIC EARNINGS Wk. Mo.	DATE OF LAST CHANGE IN EARNINGS	LAST DATE(S) WORKED # Hrs. _____	DATE(S) RETURNED TO WORK

PLEASE VERIFY THE FOLLOWING: ☐ Full Time Hrs/wk worked: _____ Wage\Salary _____

HAS EMPLOYEE BEEN TERMINATED? ☐ Yes ☐ No	IF YES, DATE	REASON	
PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD DISABILITY PREMIUM (see Internal Revenue Code Section 105(a) and Regulations thereunder) **100** %	EMPLOYEE'S CONTRIBUTIONS WERE MADE ON: ☐ Pre-or ☒ Post-tax basis	PREMIUM PAID THRU DATE	
WAS SALARY CONTINUED BEYOND LAST DAY WORKED? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	PAID THRU	
HAS EMPLOYEE RECEIVED SHORT TERM BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
HAS EMPLOYEE RECEIVED STATE DISABILITY BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
HAS EMPLOYEE FILED A WORKERS' COMPENSATION CLAIM? If yes, ☐ approved or ☐ pending? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT $	FROM	THRU

NAME AND ADDRESS OF WC CARRIER AND WC CLAIM NUMBER

IS EMPLOYEE ELIGIBLE FOR GROUP PENSION ☐ Yes ☐ No	IF YES, MONTHLY AMOUNT $	EMPLOYEE % CONTRIBUTION To Pension _____ %	EFFECTIVE	IS THIS A ☐ DISABILITY PENSION ☐ EARLY RETIREMENT ☐ NORMAL RETIREMENT

LIST ANY OTHER SOURCE OF INCOME TO WHICH THE EMPLOYEE IS ENTITLED AS A RESULT OF THIS DISABILITY

OCCUPATION (ATTACH JOB DESCRIPTION IF AVAILABLE: IF NOT, DESCRIBE JOB DUTIES BELOW)

Was employee's job primarily ☐ sedentary or ☐ did it involve considerable physical activity?

AS CLOSELY AS POSSIBLE, PLEASE ESTIMATE THE PERCENT OF TIME SPENT (TOTAL PERCENTAGE MUST EQUAL 100%):

_____ Sitting _____ Walking _____ Stooping _____ Pushing _____ Carrying **

_____ Standing _____ Climbing _____ Bending _____ Lifting

** If job duties require lifting or carrying, indicate average and maximum weights handled. _____

Is this individual covered under a life insurance policy provided by a LINA/Cigna underwriting company? (Payroll Deduction Code 0262) ☐ Yes ☐ No

If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No

REMARKS

EMPLOYER/ADMINISTRATOR	DIVISION	
ADDRESS	TELEPHONE NUMBER ( )	FAX NUMBER ( )
AUTHORIZED REPRESENTATIVE PRINT: SIGNATURE:		DATE

State of Florida Group Long Term Disability Claim Form

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

EMPLOYEE INSTRUCTIONS:

- Complete Patient/Insured section only, and forward the form to your Physician for completion.

PHYSICIAN INSTRUCTIONS:

- Answer all remaining questions, sign, and date the form.
- Mail completed form and supporting documents to: **Cigna, P.O. Box 16491, Pittsburgh, PA 15242-0791.**

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.***

PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

Please complete all relevant sections as thoroughly as possible and include medical documentation to support your findings.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED

NAME			EMPLOYER NAME
ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	GROUP POLICY NUMBER **VDT2500** ___ ___
TELEPHONE	OCCUPATION		DATE OF BIRTH

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1. DIAGNOSIS (Including any complications)

(a) Diagnosis (Include ICD-9 or DSM IV-TR Code)

(b) Subjective symptoms

(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)

(d) Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain

(e) Is illness work related? ☐ Yes ☐ No

(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____

2. DATES OF TREATMENT

(a) Date patient first visited you for this accident/illness: *Month Day Year*

(b) Date patient first unable to work due to this accident/illness: *Month Day Year*

(c) List frequency & date(s) patient was examined for this accident/illness:

(d) Date of last visit: *Month Day Year*

3. NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)

(a) Hospitalization on: *Month Day Year* **THROUGH** *Month Day Year*

(b) Surgery on: *Month Day Year* Type of Surgery:

(c) Name and Address of Hospital

(d) **Medications**	**Type**	**Dosage**

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8-hour work day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently

Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** = 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF in past year: _____ Baseline: _____

Additional Comments:

6. RETURN TO WORK STATUS	**PATIENT'S REGULAR OCCUPATION**	**ANY OTHER OCCUPATION**
When was patient able to go to work?	☐ Full-time ☐ Part-time _____ / _____ / _____ Mo. Day Yr.	☐ Full-time ☐ Part-time _____ / _____ / _____ Mo. Day Yr.

7. REMARKS

Physician Name *(Please Print)* :	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( )	Fax Number: ( ) / Federal Tax ID #:
Physician Signature:	Date:

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.