



Alta Health & Life Insurance Company
Great - West Healthcare Administered by CIGNA

Mail To: Alta Health & Life Insurance Company
c/o CIGNA Group Life and Disability Department
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free
Claims administered by CIGNA Group Insurance

Group Long Term Disability Claim Form



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

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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, 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 <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
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MAILING ADDRESS (Address where you may be reached during the next six months)	(Zip Code)	PHONE NUMBER (Includes Area Code)
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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.		<input type="checkbox"/> M <input type="checkbox"/> F		
2.		<input type="checkbox"/> M <input type="checkbox"/> F		
3.		<input type="checkbox"/> M <input type="checkbox"/> F		
4.		<input type="checkbox"/> M <input type="checkbox"/> F		
5.		<input type="checkbox"/> M <input type="checkbox"/> 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
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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
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NAMES OF HOSPITALS	COMPLETE ADDRESS	DATE ENTERED-DATE DISCHARGED
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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
<input type="checkbox"/> Yes <input type="checkbox"/> No Salary Continuance	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No State Disability Benefits	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Group Disability Benefits	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Workers' Compensation	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Pension / Retirement Benefits	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No No-Fault Auto Disability insurance (PIP)	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Any other Disability Income (please identify)	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Veterans' Benefits	_____	_____	_____

Are you covered under a life insurance policy provided by a Alta/CIGNA underwriting company? 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: _____



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TO BE COMPLETED BY THE EMPLOYER				
PLEASE COMPLETE IN FULL				
NAME OF EMPLOYEE (<i>Last, First, M.I.</i>)		SOCIAL SECURITY NO.	GROUP POLICY NUMBER	
DATE OF FULL TIME EMPLOYMENT	EFFECTIVE DATE OF EMPLOYEE'S LTD COVERAGE WITH ALTA	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: <input type="checkbox"/> Full Time Hrs/wk worked: _____ Wage\Salary _____				
HAS EMPLOYEE BEEN TERMINATED? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Pre-or <input checked="" type="checkbox"/> Post-tax basis	PREMIUM PAID THRU DATE	
WAS SALARY CONTINUED BEYOND LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WEEKLY AMOUNT \$	PAID THRU	
HAS EMPLOYEE RECEIVED SHORT TERM BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WEEKLY AMOUNT \$	FROM	THRU
HAS EMPLOYEE RECEIVED STATE DISABILITY BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WEEKLY AMOUNT \$	FROM	THRU
HAS EMPLOYEE FILED A WORKERS' COMPENSATION CLAIM? If yes, <input type="checkbox"/> approved or <input type="checkbox"/> pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WEEKLY AMOUNT \$	FROM	THRU
NAME AND ADDRESS OF WC CARRIER AND WC CLAIM NUMBER				
IS EMPLOYEE ELIGIBLE FOR GROUP PENSION <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, MONTHLY AMOUNT \$	EMPLOYEE % CONTRIBUTION To Pension _____ %	EFFECTIVE	IS THIS A <input type="checkbox"/> DISABILITY PENSION <input type="checkbox"/> EARLY RETIREMENT <input type="checkbox"/> 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 <input type="checkbox"/> sedentary or <input type="checkbox"/> 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 CIGNA underwriting company? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, does this life insurance policy contain a waiver of premium provision? <input type="checkbox"/> Yes <input type="checkbox"/> No				
REMARKS				
EMPLOYER		DIVISION		
ADDRESS			TELEPHONE NUMBER	
AUTHORIZED REPRESENTATIVE			DATE	
PRINT:		SIGNATURE:		

HAVE ALL PAGES OF THE FORM BEEN COMPLETED IN FULL?
 ATTACH THE ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY AND ANY OTHER DOCUMENTATION.

***Attach copy of pre-disability payroll statement**



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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
TELEPHONE		GROUP POLICY NUMBER
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? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain		
	(e) Is illness work related? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____		THROUGH _____ Month Day Year Month Day Year
	(b) Surgery on: _____		Type of Surgery: _____
	(c) Name and Address of Hospital		
	(d)		
	Medications	Type	Dosage

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" refers to: Life Insurance Company of North America
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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.

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.

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.