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 Life Insurance

Total and Permanent Disability / Waiver of Premium

CIGNA Group Insurance
Life • Accident • Disability

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

816175 06/2009

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.***

SECTION TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

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	Occupation *(Please attach a copy of the employee's Job Description)*	Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

Please check the appropriate blocks regarding the insured's employment status.

☐ Active ☐ Retired ☐ Salaried ☐ Hourly Hrs./Wk. _____ ☐ Full-time ☐ Part-time

Basic Annual Earnings	Date Hired	Date of Last Change in Earnings	Date of Last Increase in Benefits
Date Last Worked	Number of Hours Worked	Effective Date of Insurance	Premium Paid Through Date

Percentage of Employee Contribution Towards Premium **100%**	Employee's Contribution were made on ☐ Pre-Tax or ☒ Post-Tax Basis
Group Policy No.	Amount of Insurance

Has Employee's / Member's Coverage Terminated? ☐ Yes ☐ No **DATE(S)** **REASON**

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

Name of Employer **STATE OF FLORIDA**	Department / Agency	E-Mail Address
Address *(Street)* *City* *(State)* *(Zip Code)*		Telephone # ( )

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature of Authorized Representative	Date Signed

TO BE COMPLETED BY THE EMPLOYEE

Date of Accident or Beginning of Sickness	E-Mail Address	Did you apply for conversion of your Group Policy? ☐ Yes ☐ No If "yes", please provide policy number and effective date:

Name other sources of income to which you and your dependents are entitled by checking the appropriate sources listed below. Please indicate below the current status of Social Security Disability/Retirement benefit (check appropriate status). If you are receiving Social Security benefits, please provide us with a copy of the most recent decision (Award or Denial).

☐ Social Security

☐ Awarded ☐ Denied/No appeal has been filed ☐ Denied/Filed for Reconsideration ☐ Denied/At Administrative Law Judge Level

☐ Other (Comments) _____

☐ Pension ☐ Worker's Compensation _____ Identify Insurance Carrier _____ Policy Number

☐ Governmental

☐ Disability Insurance _____ Identify Insurance Carrier _____ Policy Number

Describe in your own words what is wrong with you. (If accident, describe circumstances)

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY THE EMPLOYEE *(Continued)*

EDUCATION

Level of Education Completed: (circle one)	High School Diploma	G.E.D.
1 2 3 4 5 6 7 8 9 10 11 12	☐ Yes ☐ No	☐ Yes ☐ No

Vocational, Business or Correspondence School (name, address, courses)

Name: _____ Name: _____

Address: _____ Address: _____

Courses: _____ Courses: _____

Certificates or Special Licenses: _____

College Education Completed: (circle one)	Major(s)	Degree(s)
1 2 3 4 5 6		

U.S. Military or Naval Science	If Yes, Special Training
☐ Yes ☐ No	

WORK HISTORY

Employer		Address	
Date Started	Date Left	Reason	
Job Title	Job Duties		Salary
Employer		Address	
Date Started	Date Left	Reason	
Job Title	Job Duties		Salary
Employer		Address	
Date Started	Date Left	Reason	
Job Title	Job Duties		Salary

MEDICAL HISTORY

Please list any hospitals, clinics or physicians that treated you during the last 3 years. (Attach a separate sheet of paper, if needed)

Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address	
Telephone ( )	Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No

Are you able to take care of all your personal care needs (grooming, dressing, etc.). If no, what areas require assistance?

_____

_____

Please indicate the chores you perform on a regular basis (check all that apply)

☐ Cooking ☐ Shopping ☐ Laundry ☐ Cleaning ☐ Child Care ☐ Yard Work, Gardening ☐ Other

Do you go for walks? ☐ Yes ☐ No If yes, how often and how far to you walk? _____

EMPLOYEE'S CERTIFICATION

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature of Employee	Date Signed

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.

ALTA

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CIGNA

Group Life Claim Form Waiver of Premium

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
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: _____

AxisIV: _____

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: ( )	Federal Tax ID #:
Physician Signature:	Date:

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

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.