CLAIM FORM INSTRUCTIONS

To help expedite the claim process, please complete the claim form in its entirety and include the below information when applicable. This information can be obtained using your online medical portal or by contacting your provider, and can be sent to Cigna at SuppHealthClaims@Cigna.com or by logging into myCigna.com and uploading. Please note we are dependent on receiving this information in a timely manner, otherwise it will delay the payment of any benefits. Below are examples of the different types of information we may need to process a claim:

- ✓ Itemized bill from hospital stay (UB04 form)
- ✓ Chart note and/or medical records to include admission and discharge paperwork, including admit and discharge times, if there was a hospital stay
- ✓ Itemized bill from accident/injury
- ✓ Medical documentation with procedure and diagnosis codes associated with the date of treatment
- ✓ Medical records with date of diagnosis of critical illness condition
- ✓ Accident report (i.e. police report) - required if claimant was driver in a motor vehicle crash
- ✓ If filing a claim on behalf of a claimant who is deceased, please include -
  - o Disclosure authorization for deceased insured (please reach out to HR to obtain)
  - o Death certificate
- ✓ Social Security Disability Insurance (SSDI) letter, if claim is for a dependent over the age of 26

There are five easy ways to file a claim:

Online myCigna.com or SuppHealthClaims.com

Email SuppHealthClaims@Cigna.com

Fax 1.866.304.3001 or 1.866.304.4307

Mail Cigna Supplemental Health Solutions
P. O. Box 188028
Chattanooga, TN 37422

Phone Call 800.754.3207 to speak with one of our dedicated customer service representatives, M-F 7am-7pm CT

CLEAR FORM

Cigna Healthcare Accidental Injury Intake Form

This document is confidential and proprietary to Cigna Healthcare

Note: * = Required field

Note: The Employee/Insured must complete Sections 1-7 and attach proof of injury, such as emergency records, itemized bills, medical records, admit/discharge summary or office notes. Proof of treatment received is required for this claim.

If you do not wish to provide additional documentation with your claim, the Attending Physician **must** complete Section 8.

SECTION 1: EMPLOYEE INFORMATION

Name *(First & Last)*:*	Social Security Number:*	Date of Birth *(mm/dd/yyyy)*:*
Address:*		
Daytime Phone Number:	Email Address:	Was the employee considered active on the date of the incident?* ☐ Yes ☐ No

If no, what was the reason the employee was not actively at work?*

☐ Family Leave (FMLA) ☐ Upaid Leave of Absence

☐ Paid Leave of Absence ☐ Other:

Does the employee have health care coverage with Cigna? ☐ Yes ☐ No

SECTION 2: EMPLOYER INFORMATION

Name of Employer *(at time of claim)*:*	Group Policy Number:

SECTION 3: DEPENDENT DEMOGRAPHIC INFORMATION *(Complete for Dependent claim only)*

Name *(First & Last)*:*	Date of Birth *(mm/dd/yyyy)*:*	Relationship to Insured:*
Address *(If different from employee)*:*		SSN: ☐ Do not have SSN

SECTION 4: CHILD'S ADDITIONAL INFORMATION: *(Complete for Child claim only)*

Is the Child a full-time student?* ☐ Yes ☐ No	If Child is not a full-time student, is he/she totally disabled?* ☐ Yes ☐ No	If adult child is disabled, please provide the SSDI Award Letter.*

SECTION 5: INFORMATION ABOUT YOUR ACCIDENT

	Date of Accident or Injury *(mm/dd/yyyy)*:*
	Did the Accident or Injury occur at work?* ☐ Yes ☐ No
	City where Accident or Injury occurred?*

SECTION 6: SPORTS BENEFIT

Was the accident due to a Sports Activity? ☐ Yes ☐ No **Note:** If 'Yes,' the next two questions are required

Was the individual coaching, officiating, or being paid for the Sports Activity? ☐ Yes ☐ No

Was the individual racing a vehicle in an organized event? ☐ Yes ☐ No

SECTION 7: LIST OF HOSPITALS, CLINICS OR PHYSICIANS

Physician/Facility Name:*	Specialty:	Phone Number:*	Fax Number:
Address:*		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	

SECTION 8: PHYSICIAN'S STATEMENT

Present Condition

When did the accident happen?*

How did the accident happen?*

Diagnosis*

Date of Surgery *(Include operative report.)**	Procedure Performed*

Is the condition the result of an accidental injury?* ☐ Yes ☐ No

Is the condition the result of an intentionally self-inflicted injury?* ☐ Yes ☐ No

Was the patient transported via ambulance to a hospital?* ☐ Yes ☐ No

Was the patient first seen at your doctor's office?* ☐ Yes ☐ No

Was the patient first seen at a facility outside of an emergency room?* ☐ Yes ☐ No

Was the patient seen in an emergency room?* ☐ Yes ☐ No

Was the patient hospitalized?* ☐ Yes ☐ No If yes, provide dates*

Additional Comments:*

SECTION 8: PHYSICIAN'S STATEMENT (cont'd)

Physician Information / Signature

Attending Physician Name *(First & Last)*:*			Degree:*
Tax Identification Number:*	Phone Number:*	Fax Number:*	
Street Address:*	City:*	State:*	Zip Code:*

Attending Physician Signature*

Date Signed*

To help expedite the claim process, please contact your provider or use your online medical portal to access records or itemized bills, and send to Cigna at SuppHealthClaims@Cigna.com or by logging into myCigna.com and uploading. Please note we are dependent on receiving this information in a timely manner, otherwise it will delay the payment of any benefits.

CAUTION: 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; (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: ***Alaska, Alabama, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia.***

New York Residents: FRAUD WARNING: 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.

Signature*

Date Signed*

The issuance of this form is not the 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; any of your social security disability advocates or representatives; 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.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

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.

_____
Claimant's Signature*

_____
Date Signed*

_____
Print Name*

_____
Date of Birth *(mm/dd/yyyy)*:*

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: Cigna Health and Life Insurance Company, Life Insurance Company of North America (LINA), and New York Life Group Insurance Company of NY (NYLGICNY) (formerly Cigna Life Insurance Company of New York).

CLICK TO PRINT

IMPORTANT CLAIM NOTICES

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas 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.

California Residents: For your protection California law requires the following statement appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

Kansas 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 thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana 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.

Maine 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 may include imprisonment, fines or a denial of insurance benefits.

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 Hampshire Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico 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 civil fines and criminal penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Puerto Rico Residents: Caution: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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: 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.

Washington 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.

West Virginia 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.

THESE POLICIES PAY LIMITED BENEFITS ONLY. THEY ARE NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DO NOT COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group insurance policies may contain exclusions, limitations, reduction in benefits, and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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