New York Life Group Benefit Solutions
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

Group/Association - Proof of Loss
Life Insurance
Accidental Death Insurance

GROUP BENEFIT SOLUTIONS

Connecticut General Life Insurance Company
Life Insurance Company of North America
New York Life Group Insurance Company of NY

831492 Rev. 01/2023

CLEAR FORM

NEW YORK 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.

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: ***Arizona, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR LIFE INSURANCE OR ACCIDENTAL DEATH PROCEEDS ONLY. COMPLETE THE FORM ACCORDING TO THE INSTRUCTIONS, TO AVOID DELAY OR RETURN OF THE FORM. **IN BOXES WHICH CONTAIN THE SYMBOL ⓘ , ADDITIONAL INFORMATION IS PROVIDED WHEN HOVERING OVER THE FIELD TO BE COMPLETED. THIS FEATURE IS ONLY AVAILABLE ON THE FILLABLE VERSION OF THIS FORM.**

To The Employer/Administrator:
A. Submit completed form to your assigned Claim Office with a certified Death Certificate and Beneficiary Designation.
B. If claiming voluntary or employee-paid benefits, include enrollment information for the current year and the previous two years (if available).

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

ⓘ Name of Employee/Member *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Employee's/Member's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Policy Number(s): List all policies under which benefits are due. | Occupation | ⓘ Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

ⓘ Check all of the boxes that apply to the Employee/Member's employment/membership status and job classification. Hrs./Wk. _____
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

ⓘ Basic Annual Earnings | ⓘ Effective Date of Earnings | ⓘ Employee's Division/Location | ⓘ Policy Class #

ⓘ Amount of Insurance: If claiming voluntary benefits, please provide enrollment information.
Life Basic: Voluntary: SIB:
AD&D *(Please complete only if claiming AD&D benefits) :* Basic: Voluntary: BTA:

ⓘ Date Hired/Member of Assoc. | ⓘ Effective Date of Insurance | ⓘ Date Last Worked | Date of Death | ⓘ Premium Paid Through Date | ⓘ Has an assignment been taken? *(If yes, attach copy)* ☐ Yes ☐ No

Was the above Considered an Employee/Association Member until his/her Date of Death? ☐ Yes ☐ No *If No, Please Explain*

ⓘ Was the Employee actively at work until the date of the Dependent's death? ☐ Yes ☐ No *If No, indicate reason below.*

ⓘ If the Employee was not actively at work immediately prior to his/her death or Dependent's death, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Minnesota Continuation *(Please attach COBRA form.)*
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged ☐ Other: _____

ⓘ Was coverage still in effect through the Date of Death? *If No, Please Explain* ☐ Yes ☐ No

ⓘ Is there a Beneficiary Designation on file for this Employee/Member? ☐ Yes ☐ No
Please provide the most recent beneficiary designation with the claim.

Did the Employee have health care coverage with Cigna? ☐ Yes ☐ No

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/Association Member | Amount of Dependent Insurance **Life** Basic: _____ Voluntary: _____ **AD&D** Basic: _____ Voluntary: _____ | Dependent's Occupation

Was the Dependent Totally Disabled? ☐ Yes ☐ No | If yes, Date Disability Began | Dependent's Last Day Worked

Dependent's Employer | Dependent's Employer's Telephone Number | Is Child ☐ Full-time student ☐ Part-time student

Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)* | School Telephone Number

EMPLOYER'S/ADMINISTRATOR'S CERTIFICATION

Name of Employer/Association | Email Address

Address *(Street)* *City* *(State)* *(Zip)* | Telephone Number

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

TO BE COMPLETED IF CLAIM IS FOR ACCIDENTAL DEATH BENEFITS

Where and How Did the Accident Happen? Please Describe in Detail	Date and Time of Accident

SECTION TO BE COMPLETED BY THE BENEFICIARY

Name of Beneficiary *(Last Name) (First Name) (Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F

Address *(Street) (City) (State) (Zip Code)*	Relationship to Deceased	Daytime Telephone No.

Email Address

Name and Address of Legal Guardian if Beneficiary is A Minor

Did the Deceased Have Other Insurance Coverage? ☐ Yes ☐ No	Type of Insurance	Policy Number(s)

Identify Insurance Carrier(s)

During the past 3 years, did the deceased use any form of tobacco product? ☐ Yes ☐ No

Please List Any Hospital, Clinics or Physicians That Treated the Deceased During the Past 5 Years.

Name	Complete Address	Treatment Period

I certify that the foregoing information is true, correct and complete to the best of my knowledge.

Beneficiary Signature _____ Date _____

Disclosure Authorization

GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

Deceased's Name: _____ **Deceased's Date of Birth:** _____

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 give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning the deceased's health condition, or health history, or regarding any advice, care or treatment provided to the deceased. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice of the deceased's physical or mental condition, or other information concerning the deceased which may be needed to determine policy claim benefits with respect to the deceased. 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. I understand that I may choose whether to receive the results of any laboratory tests or medical examinations performed. 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, Insured'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 the deceased to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning the deceased's occupation, 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 by the Company to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the deceased. 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 released 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; 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 the medical information contains information regarding drug or alcohol abuse, I understand that the deceased's 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).

I hereby represent that I am authorized to execute this Disclosure Authorization for the release of this information.

Signature of Claimant or Claimant's Authorized Representative: _____ **Date:** _____

Relationship, if other than Claimant: _____ Claimant's Date of Birth: _____

"Company" refers to: Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

CLICK TO PRINT

IMPORTANT CLAIM NOTICE

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.

California Residents: For your protection California law requires the following to 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 a 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 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.

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.

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

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

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: 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.

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.