

# Cigna Group Universal Life and Group Variable Universal Life Insurance Claim Form



*Inside this folder, you will find complete information on how to submit your claim, as well as a claim form. If you have any questions about this process, please call our Customer Service Center at 1-800-238-2125.*

## **ABOUT YOUR LIFE INSURANCE BENEFIT**

If your insurance benefit equals \$5,000 or more, Cigna will automatically open a free, interest-bearing account in your name through BNY Mellon Bank. This account, called Cignassurance<sup>®</sup>, is a safe, secure place to keep your proceeds while you decide how to best use them. It gives you easy access to your money, and allows you to earn a competitive rate of interest (similar to a money market checking account), even while your personalized drafts are in the mail on their way to you.

These personalized drafts will be mailed to you once your claim has been approved. You can immediately begin writing drafts on your account to help take care of expenses. You may keep your Cignassurance<sup>®</sup> account open for as long as you need to; however, if your account balance falls below \$250, Cigna will automatically send you a check for the balance and close the account for you.

The Cignassurance<sup>®</sup> Program offers many features to make the management of your insurance proceeds as simple and convenient as possible:

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### **GUARANTEED SAFETY**

Your entire principal and all interest earned are fully guaranteed by Connecticut General Life Insurance Company, a subsidiary of the Cigna Corporation.

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### **COMPETITIVE INTEREST RATES**

The balance in your account will continue to earn a competitive rate of interest. Interest will be compounded daily and credited monthly.

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### **FREE DRAFTS**

With the Cignassurance<sup>®</sup> account, there are no monthly service charges, no charges for drafts, and no monthly draft limits.

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### **EASY RECORD KEEPING**

Each quarter, you'll receive a statement showing any transactions and the interest earned. We'll also keep your cancelled drafts on file for you.

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### **TOTAL CONTROL**

Only proceeds from the insurance coverage may be deposited into this account, and only you will be authorized to sign any drafts from this account. This ensures you retain total control over your benefit.

**If your life insurance benefit is less than \$5,000, Cigna will send you a check for the total benefit amount.**

# Cigna Group Universal Life and Group Variable Universal Life Insurance Claim Form



## Important Instructions

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### GENERAL INFORMATION

1. Please have each beneficiary submit his or her own claim statement.
2. Along with this completed claim form, please include a copy of the insured's Death Certificate.

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### SECTION 2 - BENEFICIARY INFORMATION

1. Please be sure to describe in what capacity you are making this insurance claim. For example, you may be legally entitled to receive the insurance proceeds because you are the **beneficiary** of the policy, the **guardian of the estate** of the beneficiary, the **assignee** who was assigned the proceeds of this policy, **executor** or the **administrator** of the insured's estate, or the trustee for this policy. Simply list the appropriate term or describe your relationship to the insured in this section.
2. For the following special situations, please note that you will need to provide some additional information.
  - a) *If the beneficiary is not of legal age*, please note that a Guardian of the beneficiary's estate must be appointed. The Guardian must then complete the claim form. A copy of the appointment must also be sent in with the claim form.
  - b) *If the insurance is payable to the insured's estate*, an Administrator or Executor must be appointed. The Administrator or Executor must then complete the claim form. A copy of the appointment certificate must be sent in with the claim form.
  - c) *If the insurance is payable to a trust*, please provide a copy of the Trust Agreement. The Trustee must then complete the claim form.

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### SECTIONS 3 AND 4 - CLAIMS FOR DEPENDENT BENEFITS AND ACCIDENT DEATH BENEFITS

You will need to complete Section 3 only if you are claiming Dependent Benefits. You will need to complete Section 4 only if you are claiming Accidental Death Benefits.

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### IMPORTANT REMINDERS

1. Please review all your answers carefully to make sure they are accurate and complete. Then sign and date the form, and return it with all the necessary additional documents in the enclosed prepaid envelope.

Claim Department  
Cigna  
P.O. Box 22328  
Pittsburgh, PA 15222-0328
2. Please understand that for the protection of the policy's beneficiaries, Cigna reserves the right to require or obtain additional information.
3. If you are entitled to an insurance benefit of \$5,000 or more, your benefit will automatically be deposited into a special Cignassurance® draft account that Cigna will set up for you.
4. If your claim benefit is less than \$5,000, we will send you a check for the total benefit amount.

# Life Insurance Claim Statement

**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.

**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; (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, Kansas, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.**

So that we can process your claim as quickly and efficiently as possible, we ask that you supply the following information about yourself and the Insured. If you have any questions about how to complete this form, please call our Claim Service Center at 1-800-238-2125.

## 1. INFORMATION ABOUT THE INSURED

INSURED'S NAME _____		DATE OF BIRTH _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
ADDRESS _____		CITY/STATE/ZIP _____		
Insured's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow/Widower		<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partner
SOCIAL SECURITY # _____	POLICY # _____	CERTIFICATE # _____		
INSURED'S EMPLOYER _____		EMPLOYER PHONE # _____		
Please list any hospitals, clinics or physicians that treated the deceased during the past three years:				

NAME _____	HOSPITAL/PHYSICIAN PHONE # _____
ADDRESS _____	CITY/STATE/ZIP _____
NAME _____	HOSPITAL/PHYSICIAN PHONE # _____
ADDRESS _____	CITY/STATE/ZIP _____

## 2. BENEFICIARY INFORMATION

BENEFICIARY'S NAME _____	DATE OF BIRTH _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
ADDRESS _____	CITY/STATE/ZIP _____		
TELEPHONE # _____	SOCIAL SECURITY # _____		

If the Estate is the Beneficiary, has an Administrator or Executor been appointed or to be appointed?  Yes  No

If Yes, please provide a copy of the appointment certificate with the claim documents or when available.

## 3. IF CLAIM IS FOR DEPENDENT BENEFITS

DEPENDENT'S NAME _____	DATE OF BIRTH _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
RELATIONSHIP TO INSURED _____	DEPENDENT'S SOCIAL SECURITY # _____	DEPENDENT'S OCCUPATION _____	
DEPENDENT'S EMPLOYER _____	DEPENDENT'S LAST DAY WORKED _____	DEPENDENT'S EMPLOYER TELEPHONE NUMBER _____	

If child,  Full-time student  Part-time student

Name and address of school: \_\_\_\_\_

School Telephone No.: \_\_\_\_\_ Is this your last eligible dependent child?  Yes  No

## 4. IF CLAIM IS FOR ACCIDENTAL DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT, ENHANCED ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Please describe the Insured's accident. Include information on how it happened, as well as the date of the accident.

What diseases, illnesses or injuries did the deceased have during the past three years? \_\_\_\_\_

The issuance of this form 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.

## Cignassurance® Program

If your insurance benefit is \$5,000 or more, Cigna will automatically open a free, interest-bearing account in your name. This account, called the Cignassurance® Program, is a convenient and secure place to keep your proceeds while you decide how to best use them. Please review the attached Cignassurance® Program Disclosure Notice for full details about the account.\* Account balances are the liability of the insurance company and are not insured by the Federal Deposit Insurance Corporation or any federal agency. The insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than \$5,000, Cigna will send you a check for the total benefit amount.

\*Please read the Cignassurance® Program Disclosure Notice before signing below.

**I understand that if my benefit is \$5,000 or more, I will receive a Cignassurance® account.**

**I understand that I may write a draft for the total amount in my account at any time.**

**I understand that the account balance may be reduced for any benefit payment by the insurance company made in error.**

**I acknowledge that, if I do not separately sign the Cignassurance® Section of this Claim Form, I am not participating in the Cignassurance® Program and that I will receive a single lump sum check for the proceeds due if my claim is approved.**

Signature\*

Date

\*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form 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.

**Please remember to attach a copy of the Certificate of Death.  
We will not be able to process your claim without it.**



"Cigna" and the "Tree of Life" logo are registered service marks of Cigna Intellectual Properties, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Life Insurance Company of North America, Connecticut General Life Insurance Company and Cigna Life Insurance Company of New York, and not by Cigna Corporation.

# Disclosure Authorization



**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.

**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; (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, Kansas, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.**

**Deceased's Name:** ① \_\_\_\_\_ **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 Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Company, New England Life Insurance Company, Alta Health & Life Insurance Company, Connecticut General Life Insurance Company.

## 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.

**Beneficiary: Please complete and return to the Employer or Cigna.**



## **ELECTRONIC COMMUNICATIONS DISCLOSURE AND CONSENT**

*Please read this information carefully. Then, print and keep a copy for yourself.*

As a valued Cigna customer, we send you information about your benefits through the mail. This information may include:

- Claim forms, authorizations, disclosures, affidavits, electronic funds transfer agreements, privacy notices, and letters letting you know about changes to any of these items;
- Claim status updates letting you know that we've received a claim, or that we've updated the status of a claim;
- Letters asking you, or someone else, for additional information to help with the review of a claim.

### **Did you know that you may also give us consent to send you this information electronically?**

Cigna has an easy to use tool called **Secure Email** that allows us to communicate with you electronically. All you need is a computer, internet access, and a personal email address (called a Designated Email).

By giving us your permission, known as consent, you understand you may no longer receive information in paper form and you accept responsibility for promptly reviewing the Secure Emails you receive. This ensures you can take appropriate action so that any benefits you are eligible for are not delayed or that any rights you have are not affected.

### **What do I need to know before I give my consent?**

#### **Access to Paper Copies**

At any time, you can still request paper copies of information. Simply email us from your valid Designated Email, call customer service or send us a letter by mail. We keep copies of the information we email for the time periods required by law. We recommend saving or printing copies of the information you get electronically to ensure you have it when you need it.

#### **System Requirements**

To use Secure Email, access messages, and keep copies of the information we send you must have a working, personal Designated Email address and a computing or communications device with:

- working Internet access,
- a Web browser that supports 128-bit encryption (such as Chrome®, Firefox®, Internet Explorer®, or Safari®),
- 16 MB of available memory (32 MB of RAM recommended) and
- a program that can view, save and print PDF files (such as Adobe® Reader® 4.0 or higher).

#### **Our Right to Send Paper**

We have the right to send you information through the mail even if you agreed to receive it electronically. For example, we may send you a letter through the mail if we have a system outage, if we suspect fraud, if for any reason your Designated Email does not accept emails from us, or if we receive notification that you have not opened your email messages in Secure Email.

#### **Modification of Consent Terms**

We reserve the right to modify (change) these terms and conditions if we choose. We will provide you with notice of a modification electronically, and the date it is to go into effect. If you do not agree to the new terms and conditions, you must notify us of your Withdrawal of Consent before the effective date. Failure to withdraw your consent, or follow the instructions in the notice, lets us know that you agree to the new terms.

#### **Withdrawal of Consent**

Your consent remains in effect until you tell us otherwise and provide a Withdrawal of Consent. You may withdraw your consent at any time if you decide you want to go back to paper information. To contact us, you may email using the same valid, personal e-mail address you used to register for Secure Email, call us at 1-800-238-2125, or send us a letter by mail. Withdrawing your consent will let us know that you want to stop receiving Secure Emails. It will not change the outcome of any information we have already sent you.

**Beneficiary: Please review and keep for your records.**

## Your Consent

Please read the following paragraph, make your selection, print and sign your name, enter the date, give us your email address, and provide the employee's name and date of birth.

By signing my name below, I agree that I have read the information in this letter about Cigna's Secure Email tool and I wish to receive information electronically from Cigna. I also agree that:

1. I have technology that meets the System Requirements highlighted above,
2. I have received written instruction in this letter on how to receive and manage messages using Secure Email, and
3. I will provide and maintain a valid Designated Email and that this email belongs to me. I agree to maintain this email until I provide Cigna with a new one (if appropriate) by calling customer service or sending a letter through the mail.
4. I understand that Cigna will only send me information electronically from this point forward unless I withdraw my consent.

**If Cigna does not receive your signed Consent, Cigna will continue to send paper communications. If you do not wish to receive information electronically from Cigna, do not sign or return this form to Cigna.**

### Select One:

- I consent to receive information electronically for ALL claims for which I am eligible for benefits.
- I consent to receive information electronically ONLY for the following type of claims for which I am eligible for benefits:
- Life       Accidental Death

**Name:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_  
(Please print clearly) (Please print clearly)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Employee:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Beneficiary: Please complete and return to the Employer or Cigna if you wish to participate in electronic communications. Do not complete or return this form to the Employer or Cigna if you do not wish to participate in electronic communications.**

# How to Use Cigna Secure Email

Here's how it works.

Cigna sends an email to a secure website where you login and retrieve it. The first time you receive a Secure Email, you need to login and register. Registration confirms your identity and is completed by following these simple instructions.

1. Open the Secure Email you receive and click on the enclosed link. This opens the registration page.
2. Enter your first, middle (optional) and last name in the space provided.
3. Enter a password and password reminder that you choose.
4. Select two security questions from the drop down menu and provide answers you can easily remember.
5. Click the **register** button. An email confirmation is sent to your personal email address we have on file.
6. Now, check your personal email inbox. Open the email titled **Secure Email Registration Confirmation** and click the link. Your account is now active!

After you have successfully registered for Secure Email, you are ready to read, reply, forward and create messages.

- To Read Messages in your Inbox: The Inbox page lists messages that you received within the last 60 days. You can read, reply, forward, download and delete messages in your Inbox. In addition, you may print any message and download attachments.
- To Create a Message: The Compose option is available so that you may reach out and contact Cigna. Please note that this feature is restricted to sending messages to Cigna employees only.

## What if I forget my password?

If you forget your password, you may request a reminder from the login page (<https://www.cignasecure.com>). You need to know the personal email address you used when you registered for Secure Email.

## Where can I get help?

The Cigna Customer Support Center provides support for the Secure Email tool. You can reach them at 800-284-8346 or at 856-346-5301.

**Beneficiary: Please review and keep for your records.**



## Cignassurance® Program Disclosure Notice

### Cignassurance® Program Disclosure

If your insurance benefit is \$5,000 or more, Cigna will establish a free, interest-bearing draft account in your name. This account is a convenient and secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts (checks) will be mailed to you, once your claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. There are charges for the following special services: drafts returned unpaid (\$10), stop payment (\$12) and copy of draft or statement (\$2).

You will receive a quarterly statement for your Cignassurance® account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. You may also check your account balance online at any time at [www.cignassurance.com](http://www.cignassurance.com).

Drafts are cleared through a draft account at BNY Mellon Bank (contact information on next page). Cigna's obligation to pay is satisfied by depositing the total proceeds in the retained asset account. Drafts draw upon funds held by Cigna (whereas a "check" draws upon funds held by a banking institution). You may write an unlimited number of drafts, in any amount, at any time up to your account balance. If you wish to withdraw the proceeds in full, you can write a draft for the total amount of the account at any time. You also have the right to receive an initial lump-sum payment in the form of a bank check. Please note that Cigna reserves the right to reduce account balances for any payment made in error. You also have the right to name a beneficiary to your account. If an account becomes inactive (as defined by your State's Department of Insurance), Cigna will return any remaining balance held in a RAA to your State of residence if no named beneficiary can be located.

This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guaranty association. Please contact the National Organization of Life and Health Insurance website ([www.nolhga.com](http://www.nolhga.com)) to learn more about the coverage limitations to the account under a state guaranty association.

All funds are held by the insurance company, or one of its affiliates, which, like a bank, may earn money on the invested amounts that exceed the interest credited to the account and the cost of the additional benefits and services described below. For beneficiaries under policies issued by Connecticut General Life Insurance Company (CGLIC) and Life Insurance Company of North America (LINA), the custodian of the account funds will be CGLIC. For beneficiaries under policies issued by Cigna Life Insurance Company of New York (CLICNY), the custodian of the accounts funds will be CLICNY.

### Disclosure on Interest Earned

You earn an attractive interest rate on the funds in your Cignassurance® Program Account from the day it is established until the date it is closed. The Cignassurance® Program interest rate is reviewed weekly and will be based upon the previous week's Bank Rate Monitor Index (BRM) or any successor money market index. The BRM Index is the average annual effective yield earned on the money market accounts offered by 100 large US Bank and Thrifts across the country. Any amount that remains in the account will continue to earn interest at a rate equal to the national average bank money market rate.

Please call our toll-free number 855.836.0697 for the current rate. Both your principal and any interest you earn are guaranteed by the insurance company. Any interest earned on the account may be taxable and you should consult a tax, investment, or other financial advisor regarding tax liability and investment options. Interest earned on your account is compounded daily and is credited to your account on the fifth day of each month. All funds, including earned interest, are fully guaranteed by the insurance company.

If you have additional questions or would like additional information about the Cignassurance® Program, you can **call us at 800.570.3778**

Or write us at: Cignassurance® Program  
PO Box 534029  
Pittsburgh, PA 15253-4029

For further information, please contact your State Department of Insurance using the information provided on the next page.

Draft Accounts are setup by BNY Mellon Bank, located at 500 Ross Street, Pittsburgh, PA 15262.

*The issuance of this notice 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 with respect to the insurance.*

**Beneficiary: Please review and keep for your records.**

# Cignassurance® Program Disclosure Notice

## State Insurance Department Contact Information

**Alabama**  
PO Box 303351  
Montgomery, AL 36130  
(334) 269-3550  
[www.aldo.gov](http://www.aldo.gov)

**Alaska**  
PO Box 110805  
Juneau, AK 99811  
(800) 467-8725  
[www.commerce.alaska.gov/ins](http://www.commerce.alaska.gov/ins)

**Arizona**  
2910 N. 44th Street, STE 210  
Phoenix, AZ 85018  
(602) 364-3100  
[www.id.state.az.us](http://www.id.state.az.us)

**Arkansas**  
1200 West Third Street  
Little Rock, AR 72201  
(800) 282-9134  
[www.insurance.arkansas.gov](http://www.insurance.arkansas.gov)

**California**  
300 South Spring Street,  
South Tower  
Los Angeles, CA 90013  
(800) 927-4357  
[www.insurance.ca.gov](http://www.insurance.ca.gov)

**Colorado**  
1560 Broadway, STE 850  
Denver, CO 80202  
(800) 930-3745  
[www.dora.state.co.us/insurance](http://www.dora.state.co.us/insurance)

**Connecticut**  
153 Market Street  
Hartford, CT 06103  
(800) 203-3447  
[www.ct.gov/cid](http://www.ct.gov/cid)

**Delaware**  
841 Silver Lake Blvd.  
Dover, DE 19904  
(800) 282-8611  
[www.delawareinsurance.gov](http://www.delawareinsurance.gov)

**Florida**  
200 East Gaines Street  
Tallahassee, FL 32399  
(850) 413-3140  
[www.floir.com](http://www.floir.com)

**Georgia**  
2 Martin Luther King, Jr. Dr  
West Tower, STE 704  
Atlanta, GA 30334  
(800) 656-2298  
[www.gainsurance.org](http://www.gainsurance.org)

**Hawaii**  
PO Box 3614  
Honolulu, HI 96811  
(808) 586-2790  
[www.hawaii.gov/dcca/ins](http://www.hawaii.gov/dcca/ins)

**Idaho**  
700 West State Street  
PO Box 83720  
Boise, ID 83720  
(208) 334-4250  
[www.doi.idaho.gov](http://www.doi.idaho.gov)

**Illinois**  
320 W Washington  
Springfield, IL 62767  
(866) 445-5364  
[www.insurance.illinois.gov](http://www.insurance.illinois.gov)

**Indiana**  
311 W Washington Street,  
STE 300  
Indianapolis, IN 46204  
(317) 232-2385  
<http://www.in.gov/idoi>

**Iowa**  
330 Maple St.  
Des Moines, IA 50319  
(877) 955-1212  
[www.iid.state.ia.us](http://www.iid.state.ia.us)

**Kansas**  
420 SW 9th Street  
Topeka, KS 66612  
(800) 432-2484  
[www.ksinsurance.org](http://www.ksinsurance.org)

**Kentucky**  
PO Box 517  
Frankfort, KY 40602  
(800) 595-6053  
[www.insurance.ky.gov](http://www.insurance.ky.gov)

**Louisiana**  
1702 N. Third Street  
PO Box 94214  
Baton Rouge, LA 70802  
(800) 259-5300  
[www.lidi.louisiana.gov](http://www.lidi.louisiana.gov)

**Maine**  
34 State House Station  
Augusta, ME 04333  
(800) 300-5000  
[www.maine.gov/pfr/insurance](http://www.maine.gov/pfr/insurance)

**Maryland**  
200 St. Paul Place, STE 2700  
Baltimore, MD 21202  
(800) 492-6116  
[www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us)

**Massachusetts**  
1000 Washington Street,  
STE 810  
Boston, MA 02118  
(617) 521-7794  
[www.mass.gov/doi](http://www.mass.gov/doi)

**Michigan**  
PO Box 30220  
Lansing, MI 48909  
(877) 999-6442  
[www.michigan.gov/ofir](http://www.michigan.gov/ofir)

**Minnesota**  
85 7th Place East, STE 500  
Saint Paul, MN 55101  
(651) 296-4026  
[www.insurance.mn.gov](http://www.insurance.mn.gov)

**Mississippi**  
PO Box 79  
Jackson, MS 39205  
(800) 562-2957  
[www.mid.state.ms.us](http://www.mid.state.ms.us)

**Missouri**  
PO Box 690  
Jefferson City, MO 65102  
(573) 751-4126  
[www.insurance.mo.gov](http://www.insurance.mo.gov)

**Montana**  
840 Helena Ave.  
Helena, MT 59601  
(406) 444-2040  
[www.sao.mt.gov](http://www.sao.mt.gov)

**Nebraska**  
PO Box 82089  
Lincoln, NE 68501  
(877) 564-7323  
[www.doi.ne.gov](http://www.doi.ne.gov)

**Nevada**  
1818 E. College Pkwy.,  
STE 103  
Carson City, NV 89706  
(888) 872-3234  
[www.doi.nv.gov](http://www.doi.nv.gov)

**New Hampshire**  
21 South Fruit Street, STE 14  
Concord, NH 03301  
(800) 852-3416  
[www.nh.gov/insurance](http://www.nh.gov/insurance)

**New Jersey**  
20 West State Street  
PO Box 325  
Trenton, NJ 08625  
(800) 446-7467  
[www.state.nj.us/dobi](http://www.state.nj.us/dobi)

**New Mexico**  
1120 Paseo De Peralta  
PO Box 1269  
Santa Fe, NM 87501  
(888) 427-5772  
[www.nmprc.state.nm.us/id.htm](http://www.nmprc.state.nm.us/id.htm)

**New York**  
One State Street  
New York, NY 10004  
(800) 342-3736  
[www.dfs.ny.gov](http://www.dfs.ny.gov)

**North Carolina**  
1201 Mail Service Center  
Raleigh, NC 27699  
(800) 546-5664  
[www.ncdoi.com](http://www.ncdoi.com)

**North Dakota**  
600 E. Boulevard Ave.  
Bismarck, ND 58505  
(800) 247-0560  
[www.nd.gov/ndins](http://www.nd.gov/ndins)

**Ohio**  
50 W. Town Street, STE 300  
Columbus, OH 43215  
(800) 686-1526  
[www.insurance.ohio.gov](http://www.insurance.ohio.gov)

**Oklahoma**  
3625 NW 56th, STE 100  
Oklahoma City, OK 73112  
(800) 522-0071  
[www.ok.gov/oid](http://www.ok.gov/oid)

**Oregon**  
PO Box 14480  
Salem, OR 97309  
(888) 877-4894  
[www.cbs.state.or.us/ins/index.html](http://www.cbs.state.or.us/ins/index.html)

**Pennsylvania**  
1326 Strawberry Square  
Harrisburg, PA 17120  
(877) 881-6388  
[www.ins.state.pa.us](http://www.ins.state.pa.us)

**Rhode Island**  
1511 Pontiac Avenue  
Cranston, RI 02920  
(401) 462-9500  
<http://www.dbr.state.ri.us>

**South Carolina**  
PO Box 100105  
Columbia, SC 29202  
(803) 737-6160  
[www.doi.sc.gov](http://www.doi.sc.gov)

**South Dakota**  
445 East Capitol Avenue  
Pierre, SD 57501  
(605) 773-3563  
[www.dlr.sd.gov/insurance/default.aspx](http://www.dlr.sd.gov/insurance/default.aspx)

**Tennessee**  
500 James Robertson Pkwy.  
Nashville, TN 37243  
(615) 741-2176  
[www.tn.gov/commerce/insurance](http://www.tn.gov/commerce/insurance)

**Texas**  
PO Box 149104  
Austin, TX 78714  
(800) 252-3439  
[www.tdi.texas.gov](http://www.tdi.texas.gov)

**Utah**  
450 N State Street, STE 3110  
Salt Lake City, UT 84114  
(800) 439-3805  
[www.insurance.utah.gov](http://www.insurance.utah.gov)

**Vermont**  
89 Main Street  
Montpelier, VT 05620  
(802) 828-3301  
[www.dfr.vermont.gov](http://www.dfr.vermont.gov)

**Virginia**  
PO Box 1157  
Richmond, VA 23218  
(800) 552-7945  
[www.scc.virginia.gov/boi](http://www.scc.virginia.gov/boi)

**Washington**  
PO Box 40256  
Olympia, WA 98504  
(800) 562-6900  
[www.insurance.wa.gov](http://www.insurance.wa.gov)

**West Virginia**  
PO Box 50540  
Charleston, WV 25305  
(888) 879-9842  
[www.wvinsurance.gov](http://www.wvinsurance.gov)

**Wisconsin**  
PO Box 7873  
Madison, WI 53707  
(800) 236-8517  
[www.oci.wi.gov](http://www.oci.wi.gov)

**Wyoming**  
106 East 6th Avenue  
Cheyenne, WY 82002  
(800) 438-5768  
[www.insurance.state.wy.us](http://www.insurance.state.wy.us)

*The issuance of this notice 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 with respect to the insurance.*

**Beneficiary: Please review and keep for your records.**

## 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.

**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.

**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.

**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.