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

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

CLEAR FORM

MAIL TO: Cigna
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

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.

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, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

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:
1. **If claiming employee death benefits, please complete Sections A and C. If claiming dependent spouse or child benefits, please complete Sections A, B, and C.**
2. **If claiming voluntary or employee-paid benefits, please provide all of the enrollment history for the employee and the dependent (if claiming dependent benefits).**
3. **Please have each beneficiary review pages 1 through 10 and complete the appropriate pages.**
4. **Submit completed form to your assigned Claim Office with a Death Certificate, Beneficiary Designation and Enrollment Information, if applicable.**

SECTION A: EMPLOYEE INFORMATION

ⓘ 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:

ⓘ Has voluntary coverage for the employee/dependent been in effect continuously since enrollment? ☐ Yes ☐ No
If No, please include enrollment history and enrollment forms if not already provided.

ⓘ 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

Beneficiary: please review and keep for your records.

SECTION B: DEPENDENT SPOUSE OR DEPENDENT CHILD INFORMATION

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	Date of Marriage

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

SECTION C: 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

SECTION D: ACCIDENTAL DEATH INFORMATION

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

SECTION E: BENEFICIARY INFORMATION

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

Mailing 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 *If guardianship of the minor's estate has been established, please attach court order.*

Did the Deceased convert or port his/her life insurance coverage prior to his/her death? ☐ Yes ☐ No

If claiming voluntary life or basic and/or voluntary AD&D benefits, please list all hospital, clinics or physicians that treated the deceased within the past 5 years.

Name	**Phone Number**	**Complete Address**	**Treatment Period**

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

Beneficiary Signature _____ Date _____

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.

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

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.

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, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

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 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.

Drafts are cleared through a draft account at State Street 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 guarantee association. Please contact the National Organization of Life and Health Insurance website (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 2310
Cherry Hill, NJ 08003

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

Draft Accounts are setup by State Street Bank, located at Box 5501, Boston, Massachusetts 02206.

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.aldoi.gov

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

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

Arkansas
1200 West Third Street
Little Rock, AR 72201
(800) 282-9134
www.insurance.arkansas.gov

California
300 South Spring Street,
South Tower
Los Angeles, CA 90013
(800) 927-4357
www.insurance.ca.gov

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

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

Delaware
841 Silver Lake Blvd.
Dover, DE 19904
(800) 282-8611
www.delawareinsurance.gov

Florida
200 East Gaines Street
Tallahassee, FL 32399
(850) 413-3140
www.floir.com

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

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

Idaho
700 West State Street
PO Box 83720
Boise, ID 83720
(208) 334-4250
www.doi.idaho.gov

Illinois
320 W Washington
Springfield, IL 62767
(866) 445-5364
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

Kansas
420 SW 9th Street
Topeka, KS 66612
(800) 432-2484
www.ksinsurance.org

Kentucky
PO Box 517
Frankfort, KY 40602
(800) 595-6053
www.insurance.ky.gov

Louisiana
1702 N. Third Street
PO Box 94214
Baton Rouge, LA 70802
(800) 259-5300
www.ldi.louisiana.gov

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

Maryland
200 St. Paul Place, STE 2700
Baltimore, MD 21202
(800) 492-6116
www.mdinsurance.state.md.us

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

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

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

Mississippi
PO Box 79
Jackson, MS 39205
(800) 562-2957
www.mid.state.ms.us

Missouri
PO Box 690
Jefferson City, MO 65102
(573) 751-4126
www.insurance.mo.gov

Montana
840 Helena Ave.
Helena, MT 59601
(406) 444-2040
www.sao.mt.gov

Nebraska
PO Box 82089
Lincoln, NE 68501
(877) 564-7323
www.doi.ne.gov

Nevada
1818 E. College Pkwy.,
STE 103
Carson City, NV 89706
(888) 872-3234
www.doi.nv.gov

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

New Jersey
20 West State Street
PO Box 325
Trenton, NJ 08625
(800) 446-7467
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

New York
One State Street
New York, NY 10004
(800) 342-3736
www.dfs.ny.gov

North Carolina
1201 Mail Service Center
Raleigh, NC 27699
(800) 546-5664
www.ncdoi.com

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

Ohio
50 W. Town Street, STE 300
Columbus, OH 43215
(800) 686-1526
www.insurance.ohio.gov

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

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

Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120
(877) 881-6388
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

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

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

Texas
PO Box 149104
Austin, TX 78714
(800) 252-3439
www.tdi.texas.gov

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

Vermont
89 Main Street
Montpelier, VT 05620
(802) 828-3301
www.dfr.vermont.gov

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

Washington
PO Box 40256
Olympia, WA 98504
(800) 562-6900
www.insurance.wa.gov

West Virginia
PO Box 50540
Charleston, WV 25305
(888) 879-9842
www.wvinsurance.gov

Wisconsin
PO Box 7873
Madison, WI 53707
(800) 236-8517
www.oci.wi.gov

Wyoming
106 East 6th Avenue
Cheyenne, WY 82002
(800) 438-5768
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.

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.

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