CLEAR FORM

Proof of Loss Accident Claim Form

Life Insurance Company of North America

CIGNA

MAIL TO: CIMA
1800 N. Beauregard St., Suite 100
Alexandria, VA 22311

INQUIRIES TO:
Phone: (703) 739-9300
Toll Free: 1-800-468-4200
Fax: (703) 739-0761
E-mail: volunteers@cimaworld.com

CLAIMS ADMINISTERED BY: Preferred Care, Inc.
Fort Washington, PA

Check One:

☐ CNS/RSVP (SPS 900302) ☐ CNS/SCP ☐ CNS/FGP ☐ VIS (SPS 900303) ☐ CRASVP (SPS 900304) ☐ WRVP (SPS 900305)

CAUTION: Any person who, knowingly and with intent to defraud, or help commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. Residents of the following states, please see reverse side: ***California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas and Virginia.***

INSTRUCTIONS: The policy is Full Excess only. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company. When you receive their Benefits Statement (Explanation of Benefits or EOB) send it to us along with itemized bills.

- **Part I -** Must be completed by the Sponsoring Organization.
- **Part II -** Must be completed by the Volunteer/Patient.
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits (EOB), additional bills with record of payment or denial from primary insurance carrier, including any Medicare payment records.

PART I - POLICYHOLDER REPORT

Name of Sponsor			Client Code
Address *(Street, City, State, Zip)*			
Sponsor Contact	Phone ( )	Fax ( )	E-Mail
Name of Volunteer: Last Name First Name		Social Security No.	Date of Birth / Sex ☐ M ☐ F
Nature of Injury (Describe fully, indicating what part of body was injured - e.g. broken arm, sprained ankle)			
Describe how the Accident occurred - provide all details. Attach a separate sheet, if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**			
Describe activity Volunteer was engaged in at time of accident.			
Date of Accident	Place of Accident	Time of Accident _____ ☐ AM ☐ PM	First treatment date
Name and Title of person supervising volunteer activity.			Was he or she a witness? ☐ Yes ☐ No
List anyone present at the time of the accident.			
Please indicate to whom payments are to be made:			

Signature of Authorized Sponsoring Organization's Representative / Title **Date**

PART II - TO BE COMPLETED BY VOLUNTEER

Address of Volunteer *(Street, City, State, Zip Code)*

Telephone Number
( )

E-mail Address

Does Volunteer have health insurance other than Medicare?
☐ Yes ☐ No If Yes, please identify. _____

Is Volunteer covered by Medicare - Part A? ☐ Yes ☐ No Medicare - Part B? ☐ Yes ☐ No
Please attach bills and/or Medicare Explanation of Benefits.

NOTE: Without a complete answer to these questions, your claim cannot be processed.

Is the Volunteer enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).

Preferred Provider Organization (PPO) or similar prepaid health plan ☐ Yes ☐ No
If Yes, name of PPO or Organization _____

Health Maintenance Organization (HMO) or similar prepaid health plan ☐ Yes ☐ No
If Yes, name of HMO or Organization _____

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail will be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photocopy of the original shall be valid for the duration of this claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless otherwise specified above.

CLICK HERE TO PRINT!

Volunteer's Signature / Date

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.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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.