Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid
ACCIDENTAL INJURY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Wilson Sonsini Goodrich & Rosati

Accidental Injury coverage provides a benefit according to the schedule below when a Covered Person suffers Covered Injuries or undergoes a broad range of medical treatments or care resulting from a Covered Accident. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active Employees of the Employer regularly working a minimum of 20 hours per week, who are United States citizens or permanent resident aliens, regularly working and residing in the United States and their U.S. citizen Spouse and Dependent Children who are residing in the United States. You will be eligible for coverage immediately.
Your Spouse/Domestic Partner: Up to age 99, as long as you apply for and are approved for coverage yourself.
Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage: This Accidental Injury plan provides 24 hour coverage.
The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Initial & Emergency Care	Benefit
Ground Ambulance/Air Ambulance	$400/$1,600
Emergency Care Treatment	$300
Diagnostic Exam (x-ray or lab)	$50
Physician Office Visit	$100
Hospitalization Benefits	**Benefit**
Hospital Admission	$1,400
Hospital Stay (per day)	$300
Intensive Care Unit Stay (per day)	$600
Fractures and Dislocations	**Benefit**
Per covered surgically-repaired fracture	$200-$10,000
Per covered non-surgically-repaired fracture	$100-$5,000
Chip Fracture (percent of fracture benefit)	25%
Per covered surgically-repaired dislocation	$300-$6,000
Per covered non-surgically-repaired dislocation	$150-$3,000
Follow-Up Care	**Benefit**
Follow-up visit to the doctor	$100
Follow-up physical therapy visits	$50

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

Available Coverage — continued

Enhanced Accident Benefits	Benefit
Examples:	
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)	$480
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	$960
Coma (lasting 7 days with no response)	$10,000
Concussion	$250
Plus up to 22 additional benefits - See certificate for details, including limitations and exclusions.	

Accidental Death and Dismemberment Rider: Pays benefits for Accidental Death and Dismemberment. Examples of benefits include (but are not limited to) payment for death from Automobile accident or total and permanent loss of speech or hearing in both ears. Actual benefit amount paid depends on the type of Covered Loss. To receive benefits, the death or loss must occur within 365 days of the covered accident.

Benefit – Specific Conditions, Exclusions, Limitations & Reductions
The exclusions that apply to this benefit are in the Common Exclusions Section. If a Covered Person dies as a result of an automobile accident other loss of life benefits will not be paid. If the driver, he/she must hold a current and valid driver's license. If total and permanent loss of speech or hearing in both ears is payable, no benefits will be paid under the dismemberment benefit and total benefits will not exceed the loss of life death benefit. Benefit Amounts for the Covered Person's will reduce to 50% at age 70, but child benefits if applicable, will not reduce. This is not a complete list. See certificate for complete details, including limitations and exclusions that apply to this benefit.

Portability Feature: You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be under the age of 99 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Monthly Cost of Coverage:

Tier	Benefit
Employee	$17.79
Employee and spouse	$27.56
Employee and child(ren)	$32.77
Family	$42.54

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

Important Definitions and Policy Provisions:

Coverage Type: Benefits are paid when a covered injury results, directly and independently of all other causes, from a Covered Accident.
Covered Accident: A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the Covered Person is insured under this Policy; is not contributed to by disease, sickness, mental or bodily infirmity; and is not otherwise excluded under the terms of this Policy.
Covered Injury: Any bodily harm that results directly and independently of all other causes from a Covered Accident.
Covered Person: An eligible person who is enrolled for coverage under this Policy.
Covered Loss: A loss that is from a Covered Accident suffered by the Covered Person within the applicable time period described in the Policy.
Hospital: An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of medical doctors; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis, and charges for its services. The term Hospital does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial, educational, or nursing care; or the aged, drug addicts or alcoholics.
When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if hospital, facility or home confined, disabled or receiving disability benefits or unable to perform activities of daily living.
When your coverage ends: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)
30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Benefit Conditions and Limitations: This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy.

Common Exclusions:* In addition to any benefit specific exclusions, no payments will be made for losses caused directly or indirectly, in whole or in part, by: • intentionally self-inflicted injury, including suicide or any attempted suicide; • committing an assault or felony; • bungee jumping; parachuting; skydiving; parasailing; hang-gliding; • declared or undeclared war or act of war; • Aircraft or air travel, except as a commercial passenger or Aircraft used by the Air Mobility Command (unless owned, leased or controlled by Subscriber); • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except bacterial infection from an accidental external cut or wound or accidental ingestion of contaminated food; • activities of active military duty, except Reserve or National Guard active duty training lasting 31 days or less; • operating any vehicle under the influence of alcohol or any drug, narcotic or other intoxicant; • voluntary use of drugs, unless taken as prescribed and under direction of a physician; • services or treatment rendered by a Physician, Nurse or any other person who is: employed by the Subscriber, living with or immediate family of the Covered Person, or providing alternative medical treatments; and • injuries that occur during the course of any employment for pay, benefit or profit, excluding plans with 24 hour coverage. Actual policy terms may vary depending on your plan design and location.

Specific Benefit Exclusions & Limitations:*

• **Ground Ambulance/Air Ambulance:** Services must be provided from the scene of the Covered Accident or within 90 days of Covered Accident. Limits: payable once per Covered Accident, per Covered Person; limit 1 benefit per month; only one benefit will be paid ground/air, whichever is greater.
• **Emergency Care Treatment:** Treatment must occur within 30 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; limit 1 Covered Accidents per month. Excludes: treatment provided by an Immediate family member, clinic, or doctor's office.
• **Diagnostic Exam:** payable once per Covered Accident, per Covered Person; Treatment must occur within 90 days of the Covered Accident.
• **Physician Office Visit:** Must be diagnosed and treated by a Physician within 90 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; not payable if a Covered Person is eligible to receive a benefit under Emergency Treatment. Excludes: routine health examinations or immunizations for Covered Persons Age 60 and older, visits for Mental or Nervous Disorders, and visits by a surgeon while Confined to a Hospital. • **Hospital Admission:** Inpatient admission must occur within 90 days of the Covered Accident due to such accident; Limits: payable once per Covered Accident; limit 1 benefit per month. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Accident.

• **Hospital Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 365 days per Covered Accident; 1 benefit per month; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay. • **Intensive Care Unit Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 365 days per Covered Accident, 1 benefit per month; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay.
• **Fracture/Dislocation:** If more than one fracture, only one benefit will be paid, whichever is the greater amount. Chip fracture not paid in addition to closed fracture. Limits: Both fractures and dislocations are limited to 1 per accident. Must be diagnosed and treated by a physician within 90 days of the Covered Accident.

• **Follow-up visit to the doctor/Follow-up physical therapy visits:** Limits: 10 benefits for each Covered Person per Covered Accident for both visits to the doctor and also physical therapy visits; limit 1 Covered Accident per month for a Covered Person. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident.
• **Large Lacerations:** Treatment by physician must be received within 90 days of the Covered Accident. Limits: payable 1 time per Covered Person, Per Covered Accident; Multiple lacerations pay a maximum of 2 times the benefit. • **Coma:** Limits: payable 1 time per Covered Accident. Must be unconscious for 7 days or more with no response to external stimuli and requiring artificial respiratory or life support. Excludes: medically induced coma.
• **Concussion:** Must be diagnosed by a physician within 90 days of the Covered Accident. Limits: payable 1 time per Covered Accident.

***State Variations**

Spouse definition includes civil union for employees residing in Vermont. **Specific Benefit Exclusions and Limitations** The timeframe to obtain services following a covered accident is extended in SD and WA. **Common Exclusions** may vary for residents of MN, SC, SD, and WA. See your Certificate for detail. **Portability** in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage.

THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

Series 1.1/1.2

Terms and conditions of coverage for Accidental Injury insurance are set forth in Group Policy No. AI 960853. This is not intended as a complete description of the insurance coverage offered. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form GAI-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192

Cigna
P.O. Box 55290
Phoenix, AZ 85078
1-800-754-3207 Toll Free
1-860-730-6460 Fax
E-mail Address*: accidentinjury/criticalillness@cigna.com

Group Accidental Injury with Accidental Dismemberment, Accidental Disability and Sickness - Proof of Loss

Life Insurance Company of North America
Cigna Life Insurance Company of New York

*When transmitting communications, including documents, to this email address, please be sure to encrypt your message prior to sending. Cigna assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information.

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

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR ACCIDENTAL INJURY, ACCIDENTAL DISMEMBERMENT, PARALYSIS, LOSS OF USE, SIGHT OR HEARING BENEFITS.

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/Member

A. For all benefits, complete pages 2, 3 and 8 and review page 9.
B. If claiming Accidental Dismemberment or Paralysis or Loss of Use, Sight, Hearing or Speech Benefits, please have your physician complete page 5.
C. If claiming benefits under Sickness Rider, then complete page 4.
D. If claiming Accidental Injury Benefits, please have your physician complete page 6.
E. If claiming Accidental Disability Benefits, complete the top section of page 7 and have your physician complete the bottom section of page 7 where indicated.

SECTION TO BE COMPLETED BY THE EMPLOYEE/MEMBER OR EMPLOYEE/MEMBER AND DEPENDENT

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

Telephone Numbers
Day _____ Evening _____ | Email Address

Policy Number(s) | Occupation

Please check all of the boxes that apply to the employee's/member's employment 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

Date Hired/Member of Assoc. | Date Last Worked | Date of Accident | Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Were you an Active Employee/Member until the date of the accident? ☐ Yes ☐ No If No, Please Explain

If you were not actively at work immediately prior to your accident or your Dependent's accident, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Other:
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged _____

Do you have health care coverage with a Cigna HealthCare plan? ☐ 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/Member | Dependent's Occupation | Was the Dependent Disabled prior to the date of the accident? ☐ Yes ☐ No | If Yes, Date Disability began

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

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

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.

EMPLOYER/ASSOCIATION CONTACT INFORMATION

Name of Employer/Association	E-Mail Address
Address *(Street)* *(City)* *(State)* *(Zip Code)*	Telephone # ( )

CERTIFICATION

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE/MEMBER OR AUTHORIZED REPRESENTATIVE:	Date Signed

TO BE COMPLETED BY THE EMPLOYEE/MEMBER/DEPENDENT

Name of Employee/Member *(Last Name)* *(First Name)* *(Middle Initial)*	Social Security No.
Name of Employee/Member asking for: Claimant Name (If other than Employee/Member):	Relationship to Employee/Member:

WHERE AND HOW DID THE ACCIDENT HAPPEN? PLEASE DESCRIBE IN DETAIL.

DATE AND TIME OF ACCIDENT	WHAT DISEASES, ILLNESS OR INJURIES DID THE INJURED PERSON HAVE DURING THE PAST 3 YEARS?

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE INJURED PERSON DURING THE PAST 3 YEARS

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE/MEMBER:	DATE SIGNED

The issuance of this form is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

TO BE COMPLETED BY THE EMPLOYEE / MEMBER / DEPENDENT, if claiming benefits under your policy's Sickness Rider

Name of Employee/Member *(Last Name)*	*(First Name)*	*(Middle Initial)*	Social Security No.

Name of Dependent *(Last Name)*	*(First Name)*	*(Middle Initial)*

PLEASE DESCRIBE IN DETAILS REGARDING YOUR HOSPITALIZATION AND TREATMENT FOR YOUR INJURY OR ILLNESS.

DATE AND TIME OF INJURY OR ILLNESS	WHAT DISEASES, ILLNESS OR INJURIES DID THE INJURED PERSON HAVE DURING THE PAST 1 YEAR?

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE ILL OR INJURED PERSON DURING THE PAST 1 YEAR

NAME	COMPLETE ADDRESS	PHONE NUMBER	TREATMENT PERIOD

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE/MEMBER:	DATE SIGNED

The issuance of this form is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

PHYSICIAN'S CERTIFICATE

Completion required by physician if claiming Dismemberment or Loss of Use, Sight, Speech or Hearing benefits

PATIENT'S NAME	DATE OF BIRTH

1. PLEASE PROVIDE YOUR DIAGNOSIS.

2. PLEASE GIVE FULL DESCRIPTION OF THE INJURY.

3. ON WHAT DATE DID THE ACCIDENT OCCUR?

4. ON WHAT DATE DID THE PATIENT FIRST CONSULT YOU FOR THIS INJURY?

5. WAS THE PATIENT TREATED BY OTHER PHYSICIANS FOR THE INJURY? IF SO, PLEASE LIST THE NAMES AND ADDRESSES IF KNOWN. **NAME** **ADDRESS**

6. IF SURGERY WAS PERFORMED, PLEASE INDICATE THE TYPE OF SURGERY PERFORMED AND THE DATE

7. PLEASE LIST THE NAME AND ADDRESS OF THE HOSPITAL WHERE THE SURGERY WAS PERFORMED IF KNOWN.

8. WERE THERE ANY COMPLICATIONS FOLLOWING SURGERY? IF SO, PLEASE EXPLAIN IN DETAIL

9. WAS THE DISMEMBERMENT / PARALYSIS / LOSS A DIRECT RESULT OF INJURIES SUSTAINED IN AN ACCIDENT, INDEPENDENT OF ALL CAUSES? IF NOT, PLEASE EXPLAIN IN DETAIL.

10. IF THIS CLAIM IS FOR DISMEMBERMENT, PLEASE MARK THE EXACT POINT OF AMPUTATION ON THE DIAGRAM.

11. IF THIS CLAIM IS FOR PARALYSIS, PLEASE INDICATE THE EXTENT OF PARALYSIS ON THE DIAGRAM. ADVISE IF THE PARALYSIS IS PERMANENT, COMPLETE AND IRREVERSIBLE.

12. IF THIS CLAIM IS FOR LOSS OF SIGHT, WHAT IS THE PATIENT'S VISUAL ACUITY? IS THE LOSS TOTAL AND PERMANENT?

IS THE LOSS DUE TO THE ACCIDENT? PLEASE EXPLAIN IN DETAIL.

CAN THE VISION BE CORRECTED WITH EITHER SURGERY OR LENSES. IF SO, TO WHAT DEGREE?

DATE OF LAST EYE EXAMINATION AND VISUAL ACUITY (USING SNELLEN NOTATION): _____

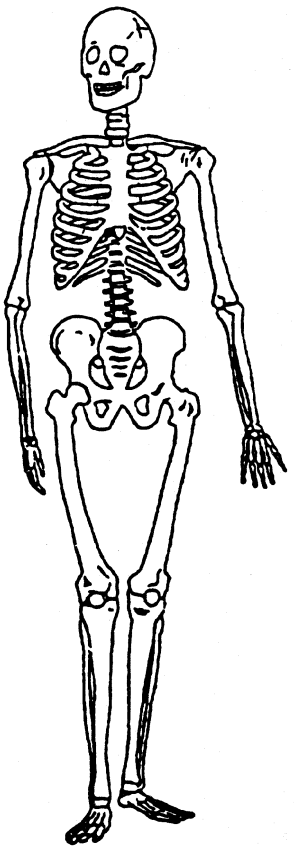
UNCORRECTED O.D. _____ **CORRECTED** O.D. _____

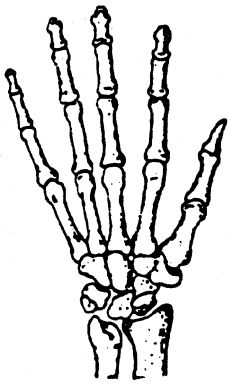
O.S. _____ O.S. _____

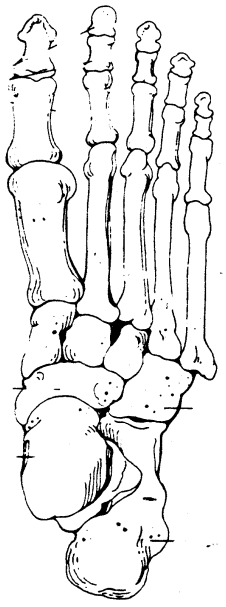
13. IF THIS CLAIM IS FOR LOSS OF SPEECH OR HEARING, PLEASE ATTACH EXAMINATION AND LABORATORY RESULTS.

14. AT THE TIME OF THE INJURY, HAD THE PATIENT BEEN DIAGNOSED FOR ANY SPECIFIC DISEASE, ILLNESS OR OLD INJURIES? IF SO, PLEASE LIST THE DIAGNOSIS.

15. IF THIS CLAIM IS IS FOR LOSS OF USE, PLEASE IDENTIFY THE AREAS AFFECTED ON THE DIAGRAM.







PHYSICIAN'S CERTIFICATE *(Continued)*

Completion required by physician if claiming Dismemberment or Loss of Use, Sight, Speech or Hearing benefits

16. WHAT PERIOD WAS THE PATIENT CONTINUOUSLY DISABLED?	**FROM**	**THROUGH**

17. HAS THE PATIENT BEEN RELEASED TO RETURN TO WORK? IF SO, PLEASE EXPLAIN IN DETAIL.

18. WOULD YOU CONSIDER THE INJURY TO BE WORK-RELATED? IF SO, PLEASE EXPLAIN IN DETAIL.

19. HAVE YOU PREPARED A REPORT OF THIS NATURE FOR ANY OTHER INSURANCE COMPANY? IF SO, PLEASE PROVIDE NAME AND ADDRESS

20. **REMARKS**

PHYSICIAN'S NAME (Please Print)	SIGNATURE		DATE
DEGREE / SPECIALTY	TAX ID #	FAX NUMBER	TELEPHONE NUMBER
STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE

PHYSICIAN'S CERTIFICATE

PHYSICIAN'S STATEMENT - PLEASE ANSWER EACH QUESTION COMPLETELY

Completion required by physician if claiming Accidental Injury Benefits

PATIENT'S NAME	DATE OF BIRTH

DATE OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	PLACE OF SERVICE

1. PLEASE PROVIDE YOUR DIAGNOSIS.

2. PLEASE GIVE FULL DESCRIPTION OF THE INJURY.

3. ON WHAT DATE DID THE ACCIDENT OCCUR?	4. ON WHAT DATE DID THE PATIENT FIRST CONSULT YOU FOR THIS INJURY?

5. WAS THE PATIENT TREATED BY OTHER PHYSICIANS FOR THE INJURY? IF SO, PLEASE LIST THE NAMES AND ADDRESSES IF KNOWN.

NAME **ADDRESS**

6. IF SURGERY WAS PERFORMED, PLEASE INDICATE THE TYPE OF SURGERY PERFORMED AND THE DATE

7. PLEASE LIST THE NAME AND ADDRESS OF THE HOSPITAL WHERE THE SURGERY WAS PERFORMED IF KNOWN.

8. WERE THERE ANY COMPLICATIONS FOLLOWING SURGERY? IF SO, PLEASE EXPLAIN IN DETAIL

9. **REMARKS**

PHYSICIAN'S NAME (Please Print)	SIGNATURE	DATE

DEGREE / SPECIALTY	TAX ID #	FAX NUMBER	TELEPHONE NUMBER

STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE

DESCRIBE THE TYPE OF PAIN OR ILLNESS YOU OR YOUR DEPENDENT ARE EXPERIENCING:

PLEASE TYPE OR PRINT BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM.
USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

DATE OF ACCIDENT OR BEGINNING OF ILLNESS	DATE FIRST UNABLE TO WORK	DATE YOU PLAN TO RETURN TO WORK	LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS

PLEASE DESCRIBE THE TYPE OF PAIN OR ILLNESS YOU OR YOUR DEPENDENT ARE EXPERIENCING.	HAVE YOU HAD THE SAME OR SIMILAR CONDITION IN THE PAST? IF SO, PLEASE DESCRIBE IN DETAIL.

PLEASE DESCRIBE YOUR JOB DUTIES IN DETAIL. WHAT PERCENT OF YOUR JOB REQUIRES PHYSICAL LABOR?

PLEASE LIST ALL BENEFITS YOU ARE RECEIVING OR ELIGIBLE TO RECEIVE UNDER ANY OTHER GROUP INSURANCE, GOVERNMENT PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE.

BENEFIT	**GROSS WEEKLY AMOUNT**	**DATE BEGAN**	**PAID THRU DATE**

HAVE YOU ELECTED CIGNA HEALTHCARE MEDICAL INSURANCE THROUGH YOUR EMPLOYER? ☐ YES ☐ NO

IF NOT, PLEASE PROVIDE THE NAME OF YOUR MEDICAL INSURANCE CARRIER _____

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED

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.

COMPLETION REQUIRED BY ATTENDING PHYSICIAN IF CLAIMING ACCIDENT DISABILITY BENEFITS

PATIENT'S NAME	DATE OF BIRTH

DIAGNOSIS AND CONCURRENT CONDITIONS, INCLUDING ICD-9 OR DSM IV-TR CODE.

IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION IF APPLICABLE.

APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT	DATE OF DELIVERY	TYPE OF DELIVERY

COMPLICATIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

DATES OF SERVICE - INCLUDE DATE OF NEXT APPOINTMENT (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT).

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF "YES", WHEN AND DESCRIBE ☐ YES ☐ NO	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

HAS PATIENT BEEN HOSPITAL CONFINED? ☐ YES ☐ NO IF "YES", CONFINED FROM _____ THRU _____

NAME AND ADDRESS OF HOSPITAL _____

NATURE OF SURGICAL PROCEDURE, IF ANY _____

☐ INPATIENT ☐ OUTPATIENT DATE PERFORMED _____

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED - (UNABLE TO WORK) From: Thru:	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

REMARKS: WE ARE INTERESTED IN ANY INFORMATION THAT WOULD BE HELPFUL TO YOUR PATIENT FOR EVALUATION OF THIS CLAIM.

PHYSICIAN'S NAME (Please Print)	SIGNATURE	DATE

DEGREE / SPECIALTY	TAX ID #	FAX NUMBER	TELEPHONE NUMBER

STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE

Disclosure Authorization

Claimant's Name: _____

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

_____ _____

(Claimant's Signature) (Date Signed)

_____ _____

(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America
Cigna Life Insurance Company of New York

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.