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

Employee-Paid

CRITICAL ILLNESS INSURANCE

SUMMARY OF BENEFITS

Prepared for: Wilson Sonsini Goodrich & Rosati

Critical Illness insurance provides a cash benefit when a Covered Person is diagnosed with a covered critical illness or event after coverage is in effect. *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.

YourSpouse/DomesticPartner: Is eligible as long as you apply for and are approved for coverage yourself.

YourChild(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage:

The benefit amounts shown will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions and limitations applicable to these benefits. Please read all of the information in this Summary and your Certificate of Insurance for more information. All Covered Critical Illness Conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	$10,000, $20,000, $30,000	Up to $30,000
Spouse/Domestic Partner	$5,000, $10,000, $15,000	Up to $15,000
Children	$5,000, $10,000	All guaranteed issue

See "Guaranteed Issue" section below for more information.

Covered Conditions	Benefit Amount
Cancer Conditions	
Skin Cancer*	$250 1x per lifetime

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions		
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Other Specified Conditions		
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	100%	100%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
Loss of Hearing	100%	Not Available

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Loss of Speech	100%	Not Available
Systemic Lupus	25%	25%
Systemic Sclerosis	25%	25%

Health Screening Test Benefit	Benefit Amount
Examples includes (but are not limited to) mammography, and certain blood tests.	$50 per day, limited to 1 per year

Benefits	
Initial Critical Illness Benefit	Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person, subject to the Maximum Lifetime Limit. A 180 days separation period between the dates of diagnosis is required.*
Recurrence Benefit	Benefit for the diagnosis of a subsequent and same Covered Condition for which an Initial Critical Illness Benefit has been paid, payable after a 12 month separation period from diagnosis of a previous Covered Condition, subject to the Maximum Lifetime Limit.
Skin Cancer Benefit	Pays benefit stated above.
Maximum Lifetime Limit	The maximum benefit payable per Covered Person is the lesser of 5 times the elected Benefit Amount or $150,000. The following benefits are not subject to this limit: Skin Cancer and Additional Benefits.

Portability Feature: You can continue 100% of coverage for all Covered Persons at the time Your coverage ends. You must be covered under the policy and 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.

Employee's Monthly Cost of Coverage:

Employee (EE)						
	$10,000		$20,000		$30,000	
Age Band	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
<25	$4.25	$5.52	$8.50	$11.04	$12.75	$16.56
25 to 29	$4.76	$6.54	$9.52	$13.08	$14.28	$19.62
30 to 34	$5.69	$8.33	$11.38	$16.66	$17.07	$24.99
35 to 39	$4.50	$11.56	$9.00	$23.12	$13.50	$34.68
40 to 44	$10.54	$16.49	$21.08	$32.98	$31.62	$49.47
45 to 49	$14.28	$22.78	$28.56	$45.56	$42.84	$68.34
50 to 54	$18.53	$29.75	$37.06	$59.50	$55.59	$89.25
55 to 59	$22.86	$36.97	$45.72	$73.94	$68.58	$110.91
60 to 64	$27.45	$45.39	$54.90	$90.78	$82.35	$136.17
65 to 69	$37.74	$56.78	$75.48	$113.56	$113.22	$170.34
70 to 74	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48
75 to 79	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48
80 to 84	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48
85 to 89	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48
90 to 94	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48
95+	$48.36	$72.16	$96.72	$144.32	$145.08	$216.48

Spouse (SP)						
	$5,000		$10,000		$15,000	
Age Band	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
<25	$2.81	$3.78	$5.61	$7.56	$8.42	$11.34
25 to 29	$3.06	$4.21	$6.12	$8.41	$9.18	$12.62
30 to 34	$3.49	$5.10	$6.97	$10.20	$10.46	$15.30
35 to 39	$4.55	$6.89	$9.09	$13.77	$13.64	$20.66
40 to 44	$6.59	$10.12	$13.17	$20.23	$19.76	$30.35

Spouse (SP)						
	$5,000		$10,000		$15,000	
Age Band	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
45 to 49	$9.44	$14.92	$18.87	$29.83	$28.31	$44.75
50 to 54	$13.09	$21.08	$26.18	$42.16	$39.27	$63.24
55 to 59	$17.17	$28.05	$34.34	$56.10	$51.51	$84.15
60 to 64	$20.91	$35.32	$41.82	$70.63	$62.73	$105.95
65 to 69	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
70 to 74	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
75 to 79	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
80 to 84	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
85 to 89	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
90 to 94	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58
95+	$28.35	$43.86	$56.69	$87.72	$85.04	$131.58

Children (CH)		
	$5,000	$10,000
	$3.10	$6.20

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.
The policy's rate structure is based on attained age, which means the premium can increase due to the increase in your age.

Important Policy Provisions and Definitions:

Covered Person: An eligible person who is enrolled for coverage under the Policy.

Covered Loss: A loss that is specified in the Policy in the Schedule of Benefits section and suffered by the Covered Person within the applicable time period described in the Policy.

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received, or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing, unless otherwise agreed upon by Cigna. 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 the covered person is confined to a hospital, facility or at home, 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. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate about when coverage may continue.)

30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate of Insurance 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 Reductions, Common Exclusions and Limitations:

Pre-Existing Condition Limitation:* In addition to any benefit-specific limitations, we will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition. The term ''Pre-existing Condition'' means any sickness or injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a physician within 6 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance. The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the date of diagnosis occurs after the Covered Person is insured under this Policy for at least 6 continuous months after the Covered Person's most recent effective date of insurance, and effective date of any added or increased amount of insurance.

Exclusions: In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss that is caused directly or indirectly, in whole or in part by any of the following: • intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; • commission or attempt to commit a felony or an assault; • declared or undeclared war or act of war; • a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization (upon our receipt of proof of service, we will refund any premium paid for this time; Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days); • voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant (''Under the influence of alcohol'', for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred) • a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

Specific Benefit Exclusions and Limitations:

The date of diagnosis must occur while coverage is in force and the condition definition must be satisfied.
Only one Initial Benefit will be paid for each Covered Condition per person and benefits will be subject to separation periods and Maximum Lifetime Limits.

Skin Cancer, basal cell/squamous cell carcinoma or certain forms of melanoma.

Invasive Cancer, uncontrolled/abnormal growth or spread of invasive malignant cells. Excludes pre-malignant conditions or conditions with malignant potential, carcinoma in situ, basal cell carcinoma, squamous cell carcinoma of the skin, unless metastatic disease develops, melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ, or prostate tumor that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale. Also excludes the recurrence or metastasis of an original Cancer that was diagnosed prior to the coverage effective date if the Insured has undergone treatment for such cancer within 12 months of being diagnosed with cancer while under this coverage.

Carcinoma in Situ, non-invasive malignant tumor. Excludes premalignant conditions or conditions with malignant potential, skin cancers (basal/squamous cell carcinoma or melanoma / melanoma in situ).

Heart Attack, includes the following that confirms permanent loss of heart muscle function: 1) EKG changes; 2) elevation of cardia enzyme.

Stroke, cerebrovascular event–for instance, cerebral hemorrhage–confirmed by neuroimaging studies or with neurological deficits lasting 96 hours or more. Excludes transient ischemic attack (TIAs), brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting eye or optic nerve or ischemic disorders of the vestibular system.

Coronary Artery Disease, heart disease/angina requiring coronary artery bypass surgery, as prescribed by a Physician. Excludes angioplasty (percutaneous coronary intervention) and stent implantation.

Advanced Alzheimer's Disease, progressive degenerative disorder that attacks the brain's nerve cells resulting in the inability to perform 3 or more of the Activities of Daily Living.

Amyotrophic Lateral Sclerosis (ALS aka Lou Gehrig's Disease), motor neuron disease resulting in muscular weakness and atrophy.

Parkinson's Disease, progressive, degenerative neurologic disease with indicated signs of the disease.

Multiple Sclerosis, disease involving damage to brain and spinal cord cells with signs of motor or sensory deficits confirmed by MRI.

Benign Brain Tumor, non-cancerous abnormal cells in the brain.

Blindness, irreversible sight reduction in both eyes; Best corrected single eye visual acuity less than 20/200 (E-Chart) or 6/60 (Metric) or with visual field reduction (both eyes) to 20 degrees or less. May require loss be due to specific illness.

Coma, unconscious state lasting at least 96 continuous hours. Excludes any state of unconsciousness intentionally or medically induced from unconsciousness intentionally which the Covered Person is able to be aroused.

End-Stage Renal (Kidney) Disease, chronic, irreversible function of both kidneys. Requires hemo or peritoneal dialysis.

Major Organ Failure, includes: liver, lung, pancreas, kidney, heart or bone marrow. Happens when transplant is prescribed or recommended and placed on UNOS registry. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable. Recurrence Benefit not payable for same organ for which a benefit was previously paid.

Paralysis, complete, permanent loss of use of two or more limbs due to a disease. Excludes loss due to Stroke, Multiple Sclerosis and Cerebral Palsy.

Loss of Hearing, permanent hearing loss in both ears; loss greater than 90dB HL. May require loss be due to specific illness.

Loss of Speech, permanent loss of speech which is irrecoverable by other means excludes loss due to specified conditions (i.e. Alzheimer's).

Systemic Lupus, chronic, inflammatory, auto-immune disease with indicated signs of the disease.

Systemic Sclerosis, chronic, degenerative, auto-immune disease with indicated signs of the disease.

Guaranteed Issue:

If you are a new hire you are not required to provide evidence of good health if you enroll during your employer's eligibility waiting period and you choose an amount of coverage up to and including the Guaranteed Issue Amount. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable evidence of good health. Guaranteed Issue coverage may be available at other specified periods of time. Your employer will notify you when these periods of time are available. Pre-existing condition limitations may apply. Your Spouse must be age 18 or older to apply if evidence of insurability is required.

***State Variations**

Spouse definition includes civil union for employees residing in Vermont. **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. **Pre-existing Condition Limitation** differs in CA, ID and SC. **Exclusions** may vary for residents of ID, MN, NC, SC, SD, VT and WA.

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 THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

Series 2.0/2.1

Terms and conditions of coverage for Critical Illness Insurance are set forth in Group Policy No. CI 960820. This is not intended as a complete description of the insurance coverage offered. This is not a contract. 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 GCI-02-1000. 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 Critical Illness Core Offering - 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.

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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 CRITICAL ILLNESS BENEFITS.

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

To The Employee/Member A. If claiming Critical Illness Benefits, please complete pages 2, 3 and 4. Review page 5.

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 | Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Were you an active Employee/Member until the date of your Critical Illness? ☐ Yes ☐ No If No, Please Explain

If you were not actively at work, 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 Critical Illness? ☐ 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)* | Dependent Telephone Number

EMPLOYER/ASSOCIATION 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. | Date Signed

SIGNATURE OF EMPLOYEE/MEMBER OR AUTHORIZED REPRESENTATIVE:

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.

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

SECTION A: (REQUIRED FOR CRITICAL ILLNESS BENEFIT)

WHAT WAS THE SPECIFIC CRITICAL ILLNESS FOR WHICH THE CLAIM IS BEING MADE?	WHEN WAS THE CRITICAL ILLNESS FIRST DIAGNOSED?	HAS THE CLAIMANT EVER HAD THIS SAME OR A SIMILAR CONDITION? ☐ Yes ☐ No

☐ Initial/Additional Critical Illness ☐ Recurrence Critical Illness

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CRITICAL ILLNESS
(Please attach a separate list if additional space is needed)

IF THE CRITICAL ILLNESS REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY
(Please attach a separate list if additional space is needed)

CLAIMANT'S OR AUTHORIZED PERSON'S SIGNATURE *(I authorize the release of any medical information necessary to process this claim).*

Signed: Date:

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.

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.