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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 (1), 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

| | | | | | | | |
|--|--|---|--|---|---------------|--|--|
| (1) Name of Employee/Member (Last Name) | | First Name | | Middle Initial | Date of Birth | Social Security No. | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Address (Street) | | City | | State | Zip Code | | |
| Employee's/Member's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed/Widower <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner Relationship <input type="checkbox"/> Civil Union | | | | | | | |
| Policy Number(s): List all policies under which benefits are due. | | | | Occupation | | (1) Was insurance issued on the basis of a statement of physical condition? (If yes, attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| (1) Check all of the boxes that apply to the Employee/Member's employment/membership status and job classification. <input type="checkbox"/> Active <input type="checkbox"/> Exempt <input type="checkbox"/> Management <input type="checkbox"/> Supervisory <input type="checkbox"/> Union Local # _____ <input type="checkbox"/> Salaried <input type="checkbox"/> Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Management <input type="checkbox"/> Non-Supervisory <input type="checkbox"/> Non-Union <input type="checkbox"/> Hourly <input type="checkbox"/> Part-time | | | | | | | |
| (1) Basic Annual Earnings | | (1) Effective Date of Earnings | | (1) Employee's Division/Location | | (1) Policy Class # | |
| (1) Amount of Insurance: If claiming voluntary benefits, please provide enrollment information. Basic: Life Voluntary: SIB: AD&D (Please complete only if claiming AD&D benefits): Basic: Voluntary: STA: | | | | | | | |
| (1) Has voluntary coverage for the employee/dependent been in effect continuously since enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please include enrollment history and enrollment forms if not already provided. | | | | | | | |
| (1) Date Hired/Member of Assoc. | | (1) Effective Date of Insurance | | (1) Date Last Worked | | (1) Premium Paid Through Date | |
| (1) Has an assignment been taken? (If yes, attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No | | (1) Was the Employee actively at work until the date of the Dependent's death? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, indicate reason below. | | | | | |
| Was the above Considered an Employee/Association Member until his/her Date of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please Explain | | | | | | | |
| (1) If the Employee was not actively at work immediately prior to his/her death or Dependent's death, what was the reason? <input type="checkbox"/> Disability (STD) <input type="checkbox"/> Paid Leave of Absence <input type="checkbox"/> FMLA <input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Resigned <input type="checkbox"/> Minnesota Continuation (Please attach COBRA form.) <input type="checkbox"/> Disability (LTD) <input type="checkbox"/> Unpaid Leave of Absence <input type="checkbox"/> Vacation <input type="checkbox"/> Sabbatical <input type="checkbox"/> Discharged <input type="checkbox"/> Other: | | | | | | | |
| Was coverage still in effect through the Date of Death? If No, Please Explain <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | (1) Is there a Beneficiary Designation on file for this Employee/Member? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide the most recent beneficiary designation with the claim. | | | |
| Did the Employee have health care coverage with Cigna? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |

Beneficiary: please review and keep for your records.

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