# Wellness Incentive Report of Claim

Life Insurance Company of North America
New York Life Group Insurance Company of NY
Cigna Health and Life Insurance Company

**If you'd like to submit your claim online, visit SuppHealthClaims.com**
There are several ways to file this claim form.
**Fax** your claim form to: 1-866-304-4307 or 1-866-304-3001
**Email** your claim form to: SuppHealthClaims@cigna.com.
**Mail** your claim form to: Cigna Supplemental Health Solutions, P.O. Box 188028, Chattanooga, TN 37422.

Clear Form

You can also call us at **1.800.754.3207** to file your claim with one of our claim specialists. Please have the following information handy: date of wellness exam/test from your medical provider(s), and any Explanation of Benefits you may have received from your medical insurance carrier.

## Cigna Wellness Incentive Claim Intake Form

This document is confidential and proprietary to Cigna

### EMPLOYEE INFORMATION:

| Name of Employee *(First & Last)*: | | Social Security Number: | Date of Birth *(mm/dd/yyyy)*: |
|---|---|---|---|
| Daytime Phone Number: | Email Address: | Group Policy Number: | |
| Address of Employee: | | | |
| Name of Employer: | Type of Benefit Claimed: | Is the employee currently working their normal work shedule? ☐ Yes ☐ No | Were you an active employee on the date of the exam/test? ☐ Yes ☐ No |

If no, what was the reason you were not actively at work?
☐ Family Leave (FMLA) ☐ Upaid Leave of Absence
☐ Paid Leave of Absence ☐ Other: _____

Do you have health care coverage with Cigna? ☐ Yes ☐ No

### DEPENDENT DEMOGRAPHIC INFORMATION: *(Complete for Spouse or Child claims)*

| Name of Dependent *(First & Last)*: | Sex of Dependent: ☐ M ☐ F | Dependent's Date of Birth *(mm/dd/yyyy)*: |
|---|---|---|
| Dependent's Relationship to Insured: | SSN (if dependent is a Child): | |
| Address of Dependent *(If different from employee)*: | | |

### CHILD'S ADDITIONAL INFORMATION: *(Complete for Child claim only)*

| Is the Child a full-time student? ☐ Yes ☐ No | If Child is a student, name and address of school: |
|---|---|
| If Child is not a full-time student, is he/she totally disabled? ☐ Yes ☐ No | If Child is totally disabled, what is his/her disabling condition? |

### WELLNESS INCENTIVE CLAIM DETAILS:

**Health Screening or Test** *(Check all that apply)*

**Date of Screening or Test** *(mm/dd/yyyy)*: _____

- ☐ Mammography
- ☐ Pap smear for women over Age 18
- ☐ Osteoporosis screenings
- ☐ Flexible sigmoidoscopy
- ☐ Hemocult stool specimen
- ☐ Colonoscopy
- ☐ Cancer screenings - including blood tests
- ☐ Stress test on bicycle or treadmill
- ☐ Fasting blood glucose test
- ☐ Blood test for triglycerides or cholesterol (HDL/LDL)
- ☐ Bone marrow testing
- ☐ Breast Ultrasound
- ☐ Chest X-ray
- ☐ Thermography
- ☐ Lead poisoning screening
- ☐ Other health screening or test: _____

*Continued on next page*

## WELLNESS INCENTIVE CLAIM DETAILS: *(Continued)*

**Wellness Visit or Exam** *(Check all that apply)* **Date of Wellness Visit or Exam** *(mm/dd/yyyy)*: _____

- ☐ Well child care - office treatment, labs or immunizations
- ☐ Routine gynecological exams
- ☐ Routine prostate exams
- ☐ Adult general health exams - office treatment, labs or immunizations
- ☐ Other wellness visit or exam:

## LOCATION AND PROVIDER NAME WHERE WELLNESS SERVICE WAS PERFORMED:

| Physician/Facility Name: | Specialty: | Phone Number: | Fax Number: |
|---|---|---|---|
| Address: | | Treatment Period: | |

**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, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia or Washington.***

**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.

☛ _____ _____

Signature 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.

# 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; any of your social security disability advocates or representatives; 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.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

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.

_____ _____

(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, New York Life Group Insurance Company of NY, Cigna Health and Life Insurance Company.

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## 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.

***Louisiana 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.

***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 Residents:*** 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 includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

***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.

***Puerto Rico Residents:*** Caution: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

***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.

***Washington 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.

THESE POLICIES PAY LIMITED BENEFITS ONLY. THEY ARE NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DO NOT 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 MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group insurance policies may contain exclusions, limitations, reduction in benefits, and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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