Application for Portability of Hospital Care Indemnity Insurance
(Hospital Indemnity Insurance)

Underwritten by Life Insurance Company of North America, a Cigna Company
(Herein called the Insurance Company)

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.

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.***

Please use this form to submit your request to continue coverage under the Portability Provision of the Policy. Please complete the form and don't forget to include your Social Security Number, your Birthdate, and to sign your name and enter today's date.

Return completed form to: Cigna
PO Box 29230
Phoenix AZ 85038-9920

EMPLOYER USE SECTION – TO BE COMPLETED BY THE EMPLOYER

Please be sure to complete all items.

Employer ____________ Policy # ____________

Employee Name ____________ Class ____________

Date Notice Completed ____________ Date Notice Provided to Employee ____________

Employee's Coverage Effective Date ____________ Spouse or Domestic Partner's Coverage Effective Date ____________

Child(ren)'s Coverage Effective Date ____________ Type of Coverage: ☐ Basic ☐ Voluntary

Hospital Care Indemnity Coverage in Force on Employee's Last Day Worked:
☐ Plan 1 ☐ Plan 2 ☐ Custom Plan ____________

Was Spouse or Domestic Partner covered? ☐ Yes ☐ No Was Child(ren) covered? ☐ Yes ☐ No

Employment Category ☐ Full-Time ☐ Part-Time

Date of Hire ____________ Last Day Worked ____________ Coverage Termination Date ____________

Employment Termination Date ____________

Reason to Initiate Portability: ☐ Change to another Class ☐ Inactive ☐ Leave of Absence ☐ Strike ☐ Termination ☐ End of Continuation Provision ☐ Layoff ☐ Military Service ☐ Retirement

Employer Signature ____________ Date ____________

Note to Employer: ***Be sure to check the group policy regarding portability limitations.***

EMPLOYEE INFORMATION

First Name ____________ Last Name ____________

Social Security Number ____________ Birthdate ____________ Gender ☐ Male ☐ Female

Address ____________ City ____________ State ______ Zip ____________

Daytime Phone ____________ Evening Phone ____________

SPOUSE OR DOMESTIC PARTNER INFORMATION

First Name ____________ Last Name ____________

Social Security Number ____________ Birthdate ____________ Gender ☐ Male ☐ Female

Do you wish to continue Hospital Care Indemnity coverage for your Spouse or Domestic Partner? ☐ Yes ☐ No

Note: ***Coverage may be continued on your Spouse or Domestic Partner only if you had coverage for them while you were actively employed.***

Please turn to other side to complete form. Be sure to make a copy for your records.

Employee Name ______________________ Social Security Number ______________

CHILD(REN) INFORMATION

Do you wish to continue Hospital Care Indemnity coverage for your dependent child(ren)? ☐ Yes ☐ No

How many children are you covering? _____

Note: Coverage may be continued on your dependent child(ren) only if you had coverage for them while you were actively employed.

GENERAL INFORMATION

1. **Eligibility** – You must be covered under the policy for the required amount of time and cannot be above the maximum age to continue your coverage. If you do not meet these requirements you will not be eligible to continue your coverage. These limitations may be reviewed in your Certificate.
2. **Rates** – You will continue with group rates, but rates may be subject to change.
3. **Deadline** – You have 31 days from the date coverage ended to exercise the portability option. Mail or fax your completed form promptly.
4. **Effective Date** – Your ported insurance will become effective on the date your insurance would otherwise have terminated, if you have applied and agreed to pay required premiums within 31 days of the date you would otherwise have ceased to be eligible.
5. **Coverage Changes** – If you have any questions on how to make changes to this coverage, please contact our Customer Service Center at 1-800-754-3207 for assistance.
6. **Billing** – You will be billed on a quarterly basis; however, your initial bill may be for a shorter or longer period of time for billing cycle reasons. After the initial bill, you will receive your bill approximately 30 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly.

SIGNATURE

If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

Please Sign Here

Employee's Signature ______________________ Date __________

Complete this form, sign and date, and return to: Cigna, P.O. Box 29230, Phoenix AZ 85038-9920 or by fax 1-800-440-0856.
Do not return this form to your employer.
For questions, please contact our Service Center toll-free at 1-800-754-3207, Monday through Friday 8 a.m. to 8 p.m. Eastern Time .

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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.

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.