Hospitalization/Mortuary Proof Of Loss

Connecticut General Life Insurance Company
Life Insurance Company of North America
Insurance Company of North America
INA Life Insurance Company of New York

CIGNA

GRAND LODGE OF CALIFORNIA ORDER SONS OF ITALY IN AMERICA
5051 Mission Street, San Francisco, CA 94112 (415) 586-1316

COMPLETE FOR ALL CLAIMS

LODGE NAME & NUMBER		POLICY SYMBOL & NUMBER SGL - 482	DATE OF MEMBERSHIP
MEMBER'S NAME		SOCIAL SECURITY NUMBER	MEMBER'S SEX ☐ Male ☐ Female
MEMBER'S ADDRESS			DATE OF BIRTH
LODGE DUES PAID TO	HOSPITAL BENEFIT PAID TO	OCCUPATION	MEMBER'S NUMBER

COMPLETE FOR DEATH CLAIMS

NAME OF BENEFICIARY	SOCIAL SECURITY NUMBER	RELATIONSHIP
ADDRESS OF BENEFICIARY		DATE OF BIRTH
☐ *BENEFICIARY NAMES CONTINUED ON REVERSE*	*Attach **certified** copy of death certificate with (embossed seal or stamp) and coroner's report if autopsy performed*	

COMPLETE FOR ALL CLAIMS

I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZED SIGNATURE AND TITLE OF LODGE OFFICER	DATE

COMPLETE FOR HOSPITAL CLAIMS

NAME OF PATIENT	
NAME AND ADDRESS OF HOSPITAL	
NATURE OF ILLNESS (DIAGNOSIS)	DATE FIRST TREATED
WAS OPERATING ROOM USED & NO. OF TIMES (Must be shown on bill/statement)	IS CONDITION CHRONIC OR RECURRENT?
NAME & ADDRESS OF ATTENDING PHYSICIAN	
SIGNATURE OF PHYSICIAN	DATE

PLEASE ATTACH COPY OF HOSPITAL BILL OR WRITTEN STATEMENT INDICATING CONFINEMENT

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history or treatment of _____
(print name of patient)

to Life Insurance Company of North America, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

SIGNATURE OF PATIENT	DATE

COMPLETE FOR DEATH CLAIMS CONTINUED		
NAME OF BENEFICIARY	SOCIAL SECURITY NUMBER	RELATIONSHIP
ADDRESS OF BENEFICIARY		DATE OF BIRTH
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