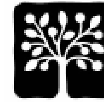
AFFIDAVIT OF DISABLED DEPENDENT CHILD

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



CIGNA Group Insurance
Life • Accident • Disability

Group Policy Number: ______________________ Group Policyholder Name: ______________________

CHILD INFORMATION

Child Name: ______________________________ Date of Birth: ______________

Social Security Number: ______________ Gender: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single

Child Address: ______________________________
Street

City: ______________________ State: ______ Zip Code: ______________

Medical Condition requiring dependency:

Date of Onset: ______________
Month/Day/Year

This is to certify that my child:

a. was eligible and met the active service requirements as defined in the effective date of coverage provision of this group policy on the date this coverage became effective,
b. continues to remain dependent upon me and meets the child definition requirements as defined under this group policy.

I am electing to continue coverage on this dependent child which would otherwise terminate on the date the child no longer is eligible as defined in the provisions of this policy.

I understand that ______________________ (*Underwriting Company*) reserves the right to examine my child periodically per the terms of the policy and such insurance for this child would terminate as the date the child no longer is a dependent child as defined by the policy.

I understand that acceptance of this authorization is not binding and ______________________ (*Underwriting Company*) may, at its discretion, perform a review of the child's circumstances at the date of death.

____
Signature of Employee

Date ______________
Month/Day/Year

____
Printed Name of Employee

____
Employee Social Security Number

____
Signature of Policyholder's Authorized Representative

Date ______________
Month/Day/Year

____
Printed Name of Authorized Representative

____
Title of Authorized Representative

IMPORTANT INFORMATION TO POLICYHOLDER

1. Keep this affidavit on file and provide a copy to the Employee.
2. This form must be supplied when filing a claim on a disabled child.
3. If this coverage is administered by CIGNA or authorized representative of CIGNA, please provide a copy of this form to that entity.