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:** _____

Please print (preferably in black ink).

CHILD INFORMATION

Child Name: _____ **Date of Birth**: _____
Month/Day/Year

Social Security Number: _____ **Gender:** ☐ Male ☐ Female **Marital Status**: ☐ Married ☐ Single

Child Address_____
Street

City_____ **State**_____ **Zip**_____

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 _____ reserves the right to examine my child periodically per the terms of the policy and such insurance for this child would terminate as of the date the child no longer is a dependent child as defined in the policy.
Underwriting Company

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

_____ _____
Signature of Employee | Signature of Policyholder's Authorized Representative

_____ _____
Date *(Month/Day/Year)* | Date *(Month/Day/Year)*

_____ _____
Printed Name of Employee | Printed Name of Authorized Representative

_____ _____
Employee Social Security Number | 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 for death benefits, conversion or portability.
3. If this coverage is administered by CIGNA or authorized representative of CIGNA, please provide a copy of this form to that entity.

Clear Fields