The Company You Keep ®

New York Life Insurance Company
Group Membership Association Claims
5505 West Cypress Street
Tampa FL 33630-3782
(800) 792-9686

Dear Claimant:

We are sorry to learn of your unfortunate illness. We understand this is a difficult time and we hope we can alleviate any concerns you might have about your claim.

We have designed this special Claim Form to simplify and speed the claim process. Please complete the Insured Statement in its entirety and have your doctor complete the Attending Physician Statement.

If you have any other insurance policies with New York Life Insurance Company or its affiliates, you should contact those offices directly to file a claim.

Please feel free to contact your Plan Administrator, if you have any questions.

Sincerely,

Cynthia Elias
Vice President

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CLAIM FORM FOR ACCELERATED DEATH BENEFITS

Revised 4/23/09

HOW TO COMPLETE YOUR CLAIM FORM

Please read this page before you start to complete your Claim Form.

Important Notice:

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax adviser.

Insured Statement

Information about the insured is necessary for purposes of identification and benefit determination. Please be sure to complete the form in its entirety and be certain to indicate the address you want all future correspondence to be mailed.

Attending Physician Statement

This from must be fully completed by your attending physician.

Certificateholders Statement

Please sign and date this section. If you have previously listed an irrevocable beneficiary, they must also sign this form.

NOTE:

It is our desire to process your claim as quickly as possible. Before submitting your claim form, please review the entire form to be sure all information is complete.

Fraud Statements

Arizona Fraud Warning

For your protection Arizona law requires the following to appear on this form: any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Fraud Warning

For your protection California Law requires the following to appear on this form: 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 Fraud Warning

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 a 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 Fraud Warning

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.

Florida Fraud Warning

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.

Maryland Fraud Warning

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and may be subject to fines and confinement in prison.

New Jersey Fraud Warning

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon Fraud Warning

Willfully falsifying material facts on an application or claim may subject you to criminal penalties.

Pennsylvania 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 subjects such person to criminal and civil penalties.

Puerto Rico Fraud Warning

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 with the penalty of 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. If aggravating circumstances are 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.

Virginia Fraud Warning

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.

Fraud Warning For All Other States

Any person who knowingly and with the 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. Penalties may include imprisonment, fines, or a denial of insurance benefits if a person provides false information.

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ACCELERATED DEATH BENEFIT CLAIM FORM
Insured Statement

Insured Information

Insured Name _____ Group Number _____

Address _____ Social Security No. _____

_____ Date of Birth _____
Month Day Year

Telephone Number ( ) _____

Nature of Illness _____ Are you totally disabled? Yes ☐ No ☐

If yes, date of total disability _____
Month Day Year

Medical Information

Please provide the names, addresses and telephone numbers of all physicians, hospitals or other medical sources who treated you within the last ten (10) years, being sure to list your family doctor in the first space provided. If necessary, use a separate piece of paper.

Doctor/Hospital Name	Address, City, State, Zip Code	Telephone Number	Dates	Condition

Insured's Statement

All providers of medical services and supplies, physicians, insurance institutions, and all medical care facilities including nursing homes and other organizations.

I authorize the release to New York Life Insurance Company, its employees, agents or other representatives any medical information required for claim processing. Information released may include records of medical advice, medical care, and medical treatment, treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use. This authorization is valid for 24 months after the date signed. A copy of this authorization shall be as valid as the original. I understand I may request a copy of this authorization. **I have read and understand the Fraud Statement that is applicable to the state in which I reside.** **New York 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

Insured Signature ***Date***

_____ _____

Owner's Signature (if owner is different than insured) ***Date***

Massachusetts Residents Only: Accelerated benefit is available only on amounts in force before January 1, 2000.

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ACCELERATED DEATH BENEFIT CLAIM FORM
Attending Physician Statement

Insured Information

Insured Name _____ Social Security Number _____

Note to Physician: Any fee for completing this statement is not chargeable to New York Life Insurance Company and should be collected from the patient.

We are particularly interested in significant history findings, diagnoses and treatment at the time this patient was diagnosed with their terminal illness. This information will be held confidential and privileged.

Diagnosis _____ Date Diagnosed _____
Month Day Year

Describe treatment or operation _____ Date of last visit _____
Month Day Year

Is the patient totally disabled from his/her OWN occupation? Yes ☐ No ☐ If yes, date total disability began _____
Month Day Year

Is the patient totally disabled from ANY occupation? Yes ☐ No ☐ If yes, date total disability began _____
Month Day Year

Please check the one which best indicates your estimate of the patient's life expectancy

☐ 12 Months or Less ☐ 13 to 18 Months ☐ 19 to 24 Months ☐ More than 24 months

Briefly describe significant medical findings to document prognosis:

_____

Have any other physician or surgeons been consulted? ☐ Yes ☐ No

If yes, please give their name, date and nature of treatment:

_____

Did another doctor refer the patient to you? ☐ Yes ☐ No

If yes, please provide their name, address and telephone number:

_____

_____ ( )
Attending Physician Name (Please Print) Degree Telephone Number

_____
Address City State Zip Code

_____
Physician Signature **Date**

New York Life Insurance Company
Group Membership Association Claims
5505 West Cypress Street, Suite 200
Tampa FL 33607

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CERTIFICATEHOLDER'S STATEMENT

I am the certificateholder under the group policy stated on the claim form. As such, I make this voluntary application to accelerate benefits without coercion on the part of any third party.

I request that any benefits remaining available at the time of my death be paid to the beneficiary recorded by New York Life Insurance Company.

I certify that I have received the illustration of what my Accelerated Benefits are and the impact it will have on my certificate.

I further understand that no health care facility can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such a facility.

NOTE – NEW YORK RESIDENTS: I acknowledge that New York Life is prohibited from paying the Accelerated Benefits for a period of 14 days from the date on which the illustration is sent to me. I further understand that no health care facility, as defined in Section 20 of the Public Health Law, can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

_____ _____

Insured Signature Date

_____ _____

Owner's Signature (if owner is different than insured) Date

TO BE COMPLETED BY THE IRREVOCABLE BENEFICIARY
(IF CURRENTLY DESIGNATED)

_____ _____

Irrevocable Beneficiary and/or Assignee Signature Date

_____

Irrevocable Beneficiary and/or Assignee (PLEASE PRINT)