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 situation. 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

The Company You Keep ®

CLAIM FORM FOR ACCIDENTAL DISMEMBERMENT BENEFITS

Revised 4/23/09

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.

The Company You Keep®

ACCIDENTAL DISMEMBERMENT CLAIM FORM

Insured Statement

Insured Information

Insured Name _____ Group Number _____

Address _____ Social Security No. _____

_____ Date of Birth _____
Month Day Year

Telephone Number ( ) _____

Dismemberment Information

Date of Accident _____ Place of Accident _____
Month Day Year

Occupation at time of Accident _____

Date last worked full time _____ Date of dismemberment _____
Month Day Year Month Day Year

Describe fully how the accident occurred, the nature of injuries received, and loss(es) for which claim is made.

_____

Did the loss arise out of, or in the course of your employment or any employer ☐ Yes ☐ No

Do you have any other life or accident insurance? ☐ Yes ☐ No

If yes, with what companies? _____

MEDICAL INFORMATION

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

Insured Signature

I authorize the release of any medical information required for claim processing to New York Life Ins. Co., its employees, agents or other representatives. This authorization is valid for 24 months from the date signed, until the claim is resolved. **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**

The Company You Keep®

ACCIDENTAL DISMEMBERMENT CLAIM FORM

Attending Physician Statement

Medical Information

Name of Patient _____ Social Security No. _____

Nature of Loss _____ Date of Loss _____
Month Day Year

How did loss occur? _____

In your opinion, was the loss due to an accident? ☐ Yes ☐ No Date of Accident _____
Month Day Year

If loss of sight is involved, in your opinion, is the loss of sight irrecoverable? ☐ Yes ☐ No

If yes, please give date on which such loss became irrecoverable _____
Month Day Year

Vision prior to accident Right Eye _____ Left Eye _____

Vision after accident Right Eye _____ Left Eye _____

If injury or disease required surgical operation (manual or instrumental) give description of operation and date performed.

_____

_____

In your opinion, was any disease an underlying cause in this loss? ☐ Yes ☐ No If yes, explain

_____

_____

Was the patient confined to a hospital as a result of the loss? ☐ Yes ☐ No If yes, please name facility

_____ ( )
Hospital or Facility Name Telephone Number

_____
Address City State Zip Code

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

_____
Address City State Zip Code

_____
Physician Signature **Date**