New York Life Insurance Company
Group Membership Association Claims
PO Box 30782
Tampa FL 33630-3782

Dear Beneficiary:

Please accept our condolences on your recent loss. We understand this is a difficult time, and we hope that we can alleviate any concerns you may have about your claim.

To help process your claim in the fastest possible manner, New York Life Insurance Company is providing this easy to use Claim Form for your convenience. Please review the form in its entirety, and then follow the step-by-step instructions to submit your claim.

New York Life Insurance Company prides itself on the speed with which it pays claims. Most claim payments are sent to the beneficiaries within ten business days from the date the Company receives the completed Claim Form, death certificate and other documents as appropriate to the claim.

Please be assured that New York Life will act as quickly as possible to complete the processing of your claim once we receive all the necessary information and documentation. If you have any questions, please contact us at 1-800-792-9686. Representatives are available between the hours of 8 a.m. to 4 p.m. (Eastern Time) Monday through Friday.

Sincerely,

Kathleen Scollan
Vice President and CFO

# CLAIM FORM FOR LIFE INSURANCE PROCEEDS

*This claim form may have been sent before New York Life has determined whether any insurance was in force at the time of death, and to whom the proceeds are payable. New York Life retains the right to make such determination.

# HOW TO COMPLETE YOUR CLAIM FORM

*Please read this before you start to complete your Claim Form*

Upon notice of the death of the insured, the Plan Administrator generally begins gathering information for your claim. To process your claim, we must have a fully completed Claim Form from each beneficiary, one certified copy of the death certificate and other documents as appropriate to the claim. You may use a photocopy of the Claim Form if there is more than one beneficiary.

## GROUP CERTIFICATE INFORMATION

Please be sure to enter all certificate numbers on the Claim Form and enclose all the original insurance certificates, if available. If not available, please explain. If the death is due to an accident or your insurance plan includes an Accidental Death benefit, it is important that you send us additional information such as a coroner's report and newspaper articles, and that you sign the Medical Authorization to avoid delay.

## DECEASED INFORMATION

Information about the deceased is necessary for purposes of identification and to help us determine if any special benefits that may have been purchased by the insured are also payable.

## BENEFICIARY INFORMATION

Information about the Beneficiary is necessary for claims processing.

Taxpayer Identification Number: In nearly all cases, life insurance benefits are not subject to income tax. However, New York Life pays interest on all proceeds from the date of death.

The Federal government requires us, and all other financial institutions; to report interest we pay you. Therefore, we are required to obtain your Social Security Number or Taxpayer Identification Number, which you must certify under penalties of perjury. If you are applying for a tax number, please write, "applied for" in the appropriate space. If you fail to supply us with an identification number, the Federal government requires us to withhold a portion of your interest as a deposit against the taxes that may be due.

Some persons have been notified by the Internal Revenue Service that they are subject to "back-up withholding" because in the past they did not report all their interest or dividends. If you have been so notified, and a back-up withholding order has not been rescinded, you must check the Back-up Withholding statement right below your Social Security or Taxpayer Identification Number. We may contact you for more information if there are any questions about your Taxpayer Identification Number or back-up withholdings status, or if you are a non-resident alien or foreign entity.

- Claims by an Estate: If an Executor or Administrator is filing the claim, he or she must sign the Claim Form and submit a certified copy of the appointment papers. Be sure to use the Tax Identification Number of the Estate. Note: A Last Will and Testament will not be accepted as proof of authority of executorship.
- Assignment: If you have assigned all or any portion of the claim to a funeral home for final expenses, please include a copy of that assignment. If the deceased assigned the policy proceeds to a bank or other financial institution, an authorized representative of that institution must sign the Claim Form.
- If the Beneficiary is a Minor: If there is a legal guardian for a minor, he or she should sign the Claim Form and submit a copy of the court document appointing the custodian of the minor child's property/estate. If no legal guardian has been appointed, payment may be considered under the Uniform Transfers to Minors Act (UTMA) subject to state guidelines. Please contact our office for further information.

## YOUR SIGNATURE

Please sign the Claim Form.

## MEDICAL INFORMATION AND AUTHORIZATION

The Medical Information and Authorization section must be completed if all or any portion of the insurance coverage is less than two years old at the time of death or you are making a claim for an accidental death.

### Illinois Interest Statement

If the certificate was issued in Illinois, you will be paid 10% interest, from the date of death, if your claim is not paid within 31 days of receiving the necessary proof needed to settle the claim.

# State Variations of Fraud Warnings

Kindly refer to the applicable fraud warnings for your state of residence.

### Alabama Fraud Warning

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

### 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime 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.

CLAIM FORM *Please type or print clearly.*
Please return this Claim Form together with a certified copy of the death certificate and any other documentation required to the address the Plan Administrator has provided to you.

## LIST ALL GROUP CERTIFICATES FOR YOUR CLAIM

_____ _____ _____

Is this claim being made for an Accidental Death Benefit? ☐ Yes ☐ No

If all or any portion of the insurance coverage began within two years of the death of the insured, or if the program contains an Accidental Death benefit and death was the result of an accident, please complete and sign the Medical Information and Authorization. In case of an accidental death, also send us copies of police or coroner's report and any news articles.

Are the Group Certificates attached? ☐ Yes ☐ No If no, please explain ☐ Lost Other _____

## DECEASED INFORMATION

Name: _____ Date of Death: _____
*Month Day Year*

List all other names by which the deceased was known: _____

Manner of Death: ☐ Natural ☐ Suicide* ☐ Accident* ☐ Homicide* ☐ Unknown ☐ Other _____

*Please attach copies of police and coroner's report and any relevant articles.

## BENEFICIARY INFORMATION

Name: _____
*First Middle Last*

Address: _____
*Street City State Zip Code*

Home Phone: ( ) _____ Alternate Phone: ( ) _____

Date of Birth: _____ Email Address: _____
*Month Day Year*

Social Security or Taxpayer Identification Number: _____

Check only if statement below applies:
☐ I have been notified by the Internal Revenue Service that I am subject to back-up withholding as a result of failure to report all interest or dividends.

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other _____

Relationship to Deceased: ☐ Spouse ☐ Child ☐ Parent ☐ Other _____

## YOUR SIGNATURE

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, with intent to defraud an insurance company or other persons, files an application for insurance or state 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 state value of the claim for each such violation.

I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and back-up withholding status information in Section 3 are correct. I further certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete form W8-BEN.)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid back-up withholding.

_____
*Signature (Required)* *Date*

## MEDICAL INFORMATION AND AUTHORIZATION

Complete this section ONLY IF all or any portion of life insurance coverage was issued within two years of the death of the insured, or if you are making a claim for an Accidental Death Benefit.

MEDICAL INFORMATION:
Please list the insured's family doctor as well as the names, addresses and telephone numbers of all physicians, clinics and hospitals that treated the insured during the past five years. If necessary, use a separate sheet of paper. This sheet must be signed and dated.

| Physician /Doctor Name | Address, City, State, Zip Code | Telephone Number | Dates | Condition |
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MEDICAL AUTHORIZATION:
I give my permission to release information concerning _____ who died on
*Name of Insured*
_____ to New York Life including its agents, parent or subsidiary companies and attorneys, reinsures, insurance support groups and independent administrators who are acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use, other insurance coverage, financial and employment history, driving records, or information otherwise needed to determine policy claim benefits due. This information may be released by medical professionals or facilities, pharmacies, pharmacy related service organizations, prescription history database suppliers, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators, any consumer reporting agency, the Social Security Administration, the Internal Revenue Service, the Veteran's Administration, or any other organization or person having any knowledge of the above named Insured. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. I understand that my claim will not be processed unless this authorization is completed and signed. Either I, or a person I choose, am entitled to receive a copy of this authorization. This authorization is valid from the date signed until the claim is resolved, except in those states, which allow for only a one-year limit.

I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on this authorization. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

*Signature* *Relationship to Insured* *Date*