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,

Kathleen Scallen

Vice President and CFO

The Company You Keep ®

CLAIM FORM FOR GROUP WAIVER OF PREMIUM BENEFITS

Revised 8/16/10

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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WAIVER OF PREMIUM BENEFIT CLAIM FORM

Insured Statement

FORM 1W

Insured Information

Insured Name ______________________ Group Number ______________

Address ______________________ Social Security No. ______________

______________________ Date of Birth ______________
Month Day Year

Telephone Number ( ) ______________________

Disability Information

Specify nature of the disability ______________________

If sickness, when did symptoms first appear? ______________________

If injury, describe When, Where and How accident occurred. ______________________

____

Occupation and duties at time of Disability ______________________

____

From what date do you claim that total disability has prevented you from performing **<u>your</u>** occupation? ______________
Month Day Year

From what date do you claim that total disability has prevented you from performing **<u>any</u>** occupation? ______________
Month Day Year

If now totally disabled, when do you expect to be able to return to work? ______________
Month Day Year

If not now totally disabled, on what date did total disability terminate? ______________
Month Day Year

Have you applied for Social Security Disability benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Have you applied for Veteran Administration benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Have you been approved for any other disability benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Insured Signature

I have read and understand the Fraud Statement that is applicable to the state in which I reside. **<u>New York Residents</u>:** 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**

Medical Information and Authorization

MEDICAL INFORMATION:

Please provide the names and addresses of all physicians and hospitals who treated the insured within the last ten (10) years.
If necessary, use a separate sheet of paper.

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

I give my permission to release information 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 advise, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use, other insurance coverage, financial and employment history. Medical professionals or facilities, pharmacies, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators, may release this information. 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. Either I, or a person I choose, may request a copy of this authorization. This authorization is valid for 24 months from the date signed until the claim is resolved.

Insured Signature _______________________ **Date** _______________

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Return this Claim Form to the address the Plan Administrator provided to you.

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WAIVER OF PREMIUM BENEFIT CLAIM FORM

Attending Physician Statement

FORM 2W

Insured Information

Insured Name ______________________ Employer Name ______________________

Date of Birth ______________________ Social Security No. ______________________
Month Day Year

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

Disability Information

History

When did symptoms first appear or accident happen? ______________________
Month Day Year

Date patient ceased work because of disability? ______________________
Month Day Year

Has patient ever had the same or similar conditions? ☐ YES ☐ NO If yes, explain: ______________________

____

Is condition due to injury or sickness arising out of patient's employment? ☐ YES ☐ NO ☐ Unknown

Name and addresses of other treating physicians: ______________________

____

Did another practitioner refer the Patient to you? ☐ YES ☐ NO If yes, provide names and addresses:

____

Diagnosis

Current Medical Condition(s)

Primary Diagnosis ______________________ ICD-9 CM Code ______________________

Secondary Diagnosis ______________________ ICD-9 CM Code ______________________

Objective finding (including X-Ray, EKG's, Laboratory Data and any clinical finding) ______________________

____

Dates of Treatment

Date of First Visit ______________________ Date of Last Visit ______________________
Month Day Year Month Day Year

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other Specify ______________________
☐ Released from Care Date Released ______________________
Month Day Year

Nature of Treatment (Including surgery and medications prescribed, if any)

____

____

Progress

Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Has patient been hospital confined? ☐ Yes ☐ No If Yes, Confined Dates ______________________

Name and Address of Hospital ______________________

Cardiac

Functional capacity (American Heart Association) ☐ Class 1 (No Limitations) ☐ Class 2 (Slight Limitations)
☐ Class 3 (Marked limitations ☐ Class 4 (Complete Limitations)

Blood Pressure (last Visit) ______________________
Systolic *Diastolic*

Mental/Nervous Impairment (if applicable)

Define "stress" as it applies to the claimant ______________________

What stress and problems in interpersonal relations has claimant had on job? ______________________

- ☐ Class 1 Patient is able to function under stress and engage in interpersonal relations. (No Limits)
- ☐ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight Limits)
- ☐ Class 3 Patient is able to engage in only limited situations and engage in limited interpersonal relations. (Moderate Limits)
- ☐ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked Limits)
- ☐ Class 5 Patient has significant loss of psychological, personal and social adjustments. (Severe Limits)

Physical Impairments (*as defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 No limits of functional capacity, capable of heavy work* No Restrictions (0-10%)
- ☐ Class 2 Medium manual activity* (15-30%)
- ☐ Class 3 Slight limitations of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- ☐ Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Prognosis

Is patient now totally disabled from **present** job? ☐ Yes ☐ No

What duties of patient's job is he/she incapable of performing? ______________________

Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

Is the patient disabled from **all** other jobs? ☐ Yes ☐ No

Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

If yes, explain ______________________

If yes, when will patient recover sufficiently to perform duties of his/her job? ______________________

When will patient recover sufficiently to perform duties of **any** job? ______________________

Dates of Total Disability From ______________ Through ______________

Dates of Partial Disability From ______________ Through ______________

Rehabilitation

Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary, speech, etc.) ☐ Yes ☐ No

When could trial employment commence? *Patient's Job* ______________ ☐ Full Time ☐ Part Time
Month Day Year

Any Other Work ______________ ☐ Full Time ☐ Part Time
Month Day Year

Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

Medical Provider's Declaration and Signature

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic Updates (including providing a copy of medical records when requested) will be required in the event of continuing claim.

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

____
Address City State Zip Code

____
Physician Signature ***Date***

ADDITIONAL INFORMATION REGARDING THE CONTINUED INTEREST ACCOUNT

For proceeds placed in a Continued Interest Account, the funds will remain with the New York Life insurance company that issued the insurance policy. Account services will be provided by the Northern Trust Company. The funds will be guaranteed by the financial strength of the insurer for as long as the proceeds remain in the Continued Interest Account; however, they are not FDIC insured.

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