



New York Life Insurance Company
Group Membership Association Claims
PO Box 30782
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 simply and speed the claim process. Please complete the Insured Statement in its entirety and have your doctor complete the Attending Physicians Statement.

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

Sincerely,

A handwritten signature in black ink that reads "Kathleen Scollan".

Kathleen Scollan
Vice President and CFO

CLAIM FORM FOR GROUP WAIVER OF PREMIUM BENEFITS

This claim form may have been sent before New York Life has determined whether any insurance was in force at the time of disability. New York Life retains the right to make such determination.

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.



WAIVER OF PREMIUM BENEFIT CLAIM FORM
Insured Statement

Form 1W

INSURED'S STATEMENT

Name: _____ Group No: _____
First Middle Last

Address: _____
Street City State Zip code

Telephone Number: () _____ Date of Birth: _____
Month Day Year

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 your occupation?

Month Day Year

From what date do you claim that total disability has prevented you from performing any occupation?

Month Day Year

If now totally disabled, when do you expect to be able to return to work?

Month Day Year

If not 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. 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.

Insured Signature (Required)

Date

MEDICAL INFORMATION AND AUTHORIZATION

MEDICAL INFORMATION:

Please provide the names addresses of all physicians and hospitals who treated the insured within the last five (5) years. If necessary, use a separate sheet of paper.

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

AUTHORIZATION FOR RELEASE OF INFORMATION

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 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.

Insured's Signature (Required)

Date



WAIVER OF PREMIUM BENEFIT CLAIM FORM
Attending Physician Statement

FORM 2W

INSURED INFORMATION

Insured Name Employer Name

Insured Date of Birth Social Security Number

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 of 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 name and addresses:

Diagnosis

Current Medical Condition(s)

Primary Diagnosis ICD9 CM Code

Secondary Diagnosis ICD9 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

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 Is patient Recovered Ambulatory Improved House Confined Unchanged Bed Confined Retrogressed Hospital Confined

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

Name and Address of Hospital

Cardiac

Functional capacity Class 1 (No Limitations) Class 2 (Slight Limitations) Class 3 (Marked Limitations) Class 4 (Complete Limitations)

American Heart Association 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 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