



*The Company you Keep*®

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

A handwritten signature in cursive script that reads "Cynthia Elias".

Cynthia Elias  
Vice President



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Revised 09/04

## CLAIM FORM FOR GROUP WAIVER OF PREMIUM BENEFITS

# Fraud Statements

## 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 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.

## 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.

## 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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

## 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 **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 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

### Claimant's Signature

**I have read and understand the Fraud Statement that is applicable to the state in which I reside.**

\_\_\_\_\_  
Insured Signature

\_\_\_\_\_  
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 disability of the insured.

### 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 |
|----------------------|--------------------------------|------------------|-------|-----------|
|                      |                                |                  |       |           |
|                      |                                |                  |       |           |
|                      |                                |                  |       |           |
|                      |                                |                  |       |           |
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|                      |                                |                  |       |           |
|                      |                                |                  |       |           |

I give my permission to release information to New York Life including its agents, parent or subsidiary companies and attorneys, reinsurers, 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. 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 \_\_\_\_\_ Group Number \_\_\_\_\_

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 Blood Pressure (last Visit))
Class 1 (No Limitations) Class 2 (Slight Limitations)
Class 3 (Marked limitations) Class 4 (Complete Limitations)
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
Any Other Work Full Time Part Time
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