



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 black ink that reads "Cynthia Elias".

Cynthia Elias
Vice President



The Company You Keep?

Revised 09/04

CLAIM FORM FOR ACCELERATED DEATH BENEFITS

Fraud Statement

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 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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ACCELERATED DEATH BENEFIT CLAIM FORM

Insured Statement

Insured Information

Insured Name _____ Group Number _____

Address _____ Social Security No. _____

_____ Date of Birth _____
 _____ Month Day Year

Telephone Number () _____

Nature of Illness _____ Are you totally disabled? Yes No

If yes, date of total disability _____
 _____ Month Day Year

Medical Information

Please provide the names, addresses and telephone numbers of all physicians, hospitals or other medical sources who treated you within the last ten (10) years, being sure to list your family doctor in the first space provided. In necessary, use a separate piece of paper.

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

Claimant's Statement

All providers of medical services and supplies, physicians, insurance institutions, and all medical care facilities including nursing homes and other organizations.

I authorize the release to New York Life Insurance Company, its employees, agents or other representatives any medical information required for claim processing. Information released may include records of medical advice, medical care, and medical treatment, treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use. This authorization is valid for 24 months after the date signed. A copy of this authorization shall be as valid as the original. I understand I may request a copy of this authorization. **I have read and understand the Fraud Statement that is applicable to the state in which I reside.**

Owners Signature

Date

OVER

Massachusetts Residents Only: Accelerated benefit is available only on amounts in force before January 1, 2000



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ACCELERATED DEATH BENEFIT CLAIM FORM

Attending Physician Statement

Insured Information

Insured Name _____ Social Security Number _____

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

We are particularly interested in significant history findings, diagnoses and treatment at the time this patient was diagnosed with their terminal illness. This information will be held confidential and privileged.

Diagnosis _____ Date Diagnosed _____
Month Day Year

Describe treatment or operation _____ Date of last visit _____
Month Day Year

Is the patient totally disabled from his/her OWN occupation? Yes No If yes, date total disability began _____
Month Day Year

Is the patient totally disabled from ANY occupation? Yes No If yes, date total disability began _____
Month Day Year

Please check the one which best indicates your estimate of the patient's life expectancy
 12 Months or Less 13 to 18 Months 19 to 24 Months More than 24 months

Briefly describe significant medical findings to document prognosis:

Have any other physician or surgeons been consulted? Yes No

If yes, please give their name, date and nature of treatment:

Did another doctor refer the patient to you? Yes No

If yes, please provide their name, address and telephone number:

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

Address _____ City _____ State _____ Zip Code _____

Physician Signature _____ Date _____



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CERTIFICATEHOLDER'S STATEMENT

I am the certificateholder of the insurance described above. As such, I make this voluntary application to accelerate benefits without coercion on the part of any third party.

I request that any benefits remaining available at the time of my death be paid to the beneficiary recorded by New York Life Insurance Company.

I certify that I have received the illustration of what my Accelerated Benefits are and the impact it will have on my policy.

I further understand that no health care facility can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such a facility.

NOTE – NEW YORK RESIDENTS: I acknowledge that New York Life is prohibited from paying the Accelerated Benefits for a period of 14 days from the date on which the illustration is sent to me. I further understand that no health care facility, as defined in Section 20 of the Public Health Law, can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Signature of Certificateholder

Date

Signature of Assignee if ownership has been transferred

Date

TO BE COMPLETED BY THE IRREVOCABLE BENEFICIARY (IF CURRENTLY DESIGNATED)

Signature of Irrevocable Beneficiary

Date

Name of Irrevocable Beneficiary (PLEASE PRINT)