



DISABILITY INCOME CLAIM INSTRUCTIONS
 (PLEASE KEEP THIS NOTICE FOR FUTURE REFERENCE)

Please answer all questions on the Member's Statement of your Disability Income and sign and date the bottom of page 2 where indicated. Also sign and date the Authorization for Release of Information on Page 3 and have your Medical Provider complete the rest of the form. Please see that the completed form is returned to:

New York Life Insurance Company
 Group Membership Association Disability Claims
 PO Box 8310
 Sleepy Hollow, NY 10591-8310

If you recover or return to work, please notify New York Life immediately by completing and mailing the statement below to the above address.

If you have any questions concerning your claim, you may call the New York Life Disability Claims Unit at (800) 695-4226.

STATEMENT OF RECOVERY OR RETURN TO WORK
 (PLEASE COMPLETE FULLY AND DETACH BEFORE MAILING)

Name: _____

Address: _____

Social Security No.: ____ - ____ - ____

Policy G-29201-0

recovered: Returned to work

on ____ / ____ / ____
 Mo. Day Year

Other: _____

Date: _____

Signature: _____

 Print Name



AMERICAN CHEMICAL SOCIETY DISABILITY INCOME CLAIM FORM

Name: _____ Date of Birth: ____/____/____
 Social Security Number: ____-____-____ Male Female
 Residential Street Address: _____
 (No.) (Street) (City or Town) (State) (Zip Code)
 Telephone No. Home () _____ Work () _____ Height: _____ Weight: _____
 Employer's Name: _____ Normal Number of Hours Worked Per Week: _____

Employer's Street Address: _____ Date Last Worked: ____/____/____

Percentage of DI Premium Paid By Member _____% Percentage of DI Premium Paid By Employer _____%
 Average Monthly Earned Income During The Twelve Months Prior To Disability
 Gross \$ _____ Net \$ _____ Self Employed Yes No

Is disability due to an accident (including automobile accident)? Yes No If "Yes" when? ____/____/____

Where? _____

How? _____

Date first treated for this disability ____/____/____ Date first unable to work ____/____/____

Have you attempted to return to your occupation since the date disability began? (If so, give details) _____

If returned to work or recovered give date ____/____/____ Returned to Work Part Time Full Time If part time, number of hours per day: _____

If not returned, when do you expect to do so? _____

NAMES AND ADDRESS OF FIRST PROVIDER CONSULTED AND OTHER PROVIDERS SEEN INCLUDING YOUR PRESENT ATTENDING PROVIDER

- | | | |
|-------------|-----------------|-----------------------------|
| Name) _____ | (Address) _____ | Telephone No. _____ |
| | | Treated From _____ To _____ |
| Name) _____ | (Address) _____ | Telephone No. _____ |
| | | Treated From _____ To _____ |
| Name) _____ | (Address) _____ | Telephone No. _____ |
| | | Treated From _____ To _____ |
| Name) _____ | (Address) _____ | Telephone No. _____ |
| | | Treated From _____ To _____ |
| Name) _____ | (Address) _____ | Telephone No. _____ |
| | | Treated From _____ To _____ |

OCCUPATION: _____

Please fully describe the duties of your occupation at the time you stopped working, including the percentage at each activity.

What are your daily activities at this time? _____

Are you receiving or will you be entitled to receive benefits from any of the following: Social Security Law? Yes No

Salary or other compensation? Yes No Pension Plan? Yes No Another Group Insurance Plan? Yes No

Individual Disability Income Policy? Yes No

If any of the above was answered "Yes", please complete the information requested below:

Policy No.	Claim No.	Name and Address	Amount of Payment

I declare that the answers on this Page 1 and Page 2 of this form are complete and true to the best of my knowledge. Furthermore, I agree that I will advise New York Life Insurance Company of my return to any type of work and I will return payments to which I am not entitled to by reason of my return to work, termination of my Covered Disability or receipt of any of the OTHER INCOME BENEFITS stipulated in my Certificate..

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Date: _____ / _____ / _____
MO DAY YEAR

Member's Signature: _____

The Member or someone on his/her behalf must Sign here and on the Authorization For Release Of Information



New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 8310
Sleepy Hollow, NY 10591-8310

Authorization for Release Of Information

TO: All providers of medical services and supplies, employers, insurance institutions, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying New York Life in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

Patient's Signature

Date

Print

Social Security No.: _____ - _____ - _____

MEDICAL PROVIDER'S STATEMENT

(The patient is responsible for the completion of this form without expense to the Company)

Notice to Provider: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME: _____ DATE OF BIRTH: _____
(First) (Middle) (Last) MM DD YYYY

2. CURRENT MEDICAL CONDITION(s):
PRIMARY DIAGNOSIS: _____ ICD-9 CM CODE: _____
SECONDARY DIAGNOSIS: _____ ICD-9 CM CODE: _____

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: _____
(Month) (Day) (Year)

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: _____
(Month) (Day) (Year)

DATE THAT PATIENT LAST CONSULTED YOU FOR THIS CONDITION: _____
(Month) (Day) (Year)

5. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES NO
(If "Yes", please provide the name and address of that practitioner): _____

6. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR INJURY OR SICKNESS? YES NO
(If "Yes", please provide details and dates of prior treatment): _____

7. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES NO
(If "Yes", provide diagnosis(es) and dates of prior treatment): _____

8. OBJECTIVE FINDINGS *(Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDC):* _____

9. HAS PATIENT BEEN HOSPITALIZED? YES NO *(If "YES", provide reason, hospital name and dates of confinement):* _____

10. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: *(Include surgery and medications prescribed if applicable)* _____

MEDICAL PROVIDER'S STATEMENT

(Continued From Previous Side)

11. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? YES NO (If "Yes", please provide the name and address of all applicable physicians or practitioners): _____

12. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? YES NO
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? _____
(MO) / (DAY) / (YEAR)

13. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES NO (If "Yes", please describe) _____

14. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:
a) THE PATIENT WAS UNABLE TO WORK FROM: _____ THROUGH: _____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)
b) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: _____ THROUGH: _____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

15. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO HIS OR HER MEDICAL CONDITION (If none, indicate "NONE"): _____

16. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES NO
IF "YES" DATE RELEASED FROM YOUR CARE: _____ IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: _____
(MO) / (DAY) / (YEAR) (MO) / (DAY) / (YEAR)

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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 copies of medical records when requested) will be required in the event of a continuing claim.

PROVIDER'S NAME/SPECIALTY (PLEASE PRINT) TAX ID/SOCIAL SECURITY # () TELEPHONE NUMBER

STREET ADDRESS CITY STATE ZIPCODE

PROVIDER'S SIGNATURE DATE SIGNED



IMPORTANT NOTICE

Whenever a claim form is given to an insured who lives in any of the states listed below, this "Important Notice" must be attached to the claim form.

FOR ALASKA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR ARIZONA RESIDENTS

"For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for the 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."

FOR CALIFORNIA RESIDENTS

"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."

FOR COLORADO RESIDENTS

"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 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."

FOR DELAWARE RESIDENTS

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR DISTRICT OF COLUMBIA RESIDENTS

"WARNING: It is a crime provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FOR FLORIDA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS

"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS

"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR INDIANA RESIDENTS

"A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony."

FOR KENTUCKY RESIDENTS

"Any person who knowingly, and with intent to defraud any insurance company or other person files a 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."

FOR LOUISIANA RESIDENTS

"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."

