



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 situation. 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



The Company You Keep?

CLAIM FORM FOR ACCIDENTAL DISMEMBERMENT 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 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.



The Company You Keep®

ACCIDENTAL DISMEMBERMENT CLAIM FORM

Insured Statement

Insured Information

Insured Name _____ Group Number _____
 Address _____ Social Security No. _____
 _____ Date of Birth _____
 _____ Month Day Year
 Telephone Number () _____

Dismemberment Information

Date of Accident _____ Place of Accident _____
 _____ Month Day Year
 Occupation at time of Accident _____
 Date last worked full time _____ Date of dismemberment _____
 _____ Month Day Year _____ Month Day Year

Describe fully how the accident occurred, the nature of injuries received, and loss(es) for which claim is made.

Did the loss arise out of, or in the course of your employment or any employer Yes No

Do you have any other life or accident insurance? Yes No

If yes, with what companies? _____

MEDICAL INFORMATION

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

Insured Signature

I authorize the release of any medical information required for claim processing to New York Life Ins. Co., its employees, agents or other representatives. This authorization is valid for 24 months from the date signed, until the claim is resolved. **I have read and understand the Fraud Statement that is applicable to the state in which I reside.**

Insured Signature

Date

OVER



The Company You Keep®

ACCIDENTAL DISMEMBERMENT CLAIM FORM

Attending Physician Statement

Medical Information

Name of Patient _____ Social Security No. _____

Nature of Loss _____ Date of Loss _____
Month Day Year

How did loss occur? _____

In your opinion, was the loss due to an accident? Yes No Date of Accident _____
Month Day Year

If loss of sight is involved, in your opinion, is the loss of sight irrecoverable? Yes No

If yes, please give date on which such loss became irrecoverable _____
Month Day Year

Vision prior to accident Right Eye _____ Left Eye _____

Vision after accident Right Eye _____ Left Eye _____

If injury or disease required surgical operation (manual or instrumental) give description of operation and date performed.

In your opinion, was any disease an underlying cause in this loss? Yes No If yes, explain

Was the patient confined to a hospital as a result of the loss? Yes No If yes, please name facility

Hospital or Facility Name _____ Telephone Number _____
()

Address _____ City _____ State _____ Zip Code _____

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

Address _____ City _____ State _____ Zip Code _____

Physician Signature

Date