NEW YORK LIFE GROUP BENEFIT SOLUTIONS

CLEAR FORM

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Attending Physician Statement for Critical Illness

New York Life Group Benefit Solutions
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New York Life Insurance and Annuity Corporation

NEW YORK 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the section titled "Important Claim Notice" of this form: ***Arizona, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

Employee Information

First Name	Last Name	Birthdate (MM/DD/YYYY)	Social Security Number

Claimant and Patient Information

Who is the claimant and patient? ☐ Employee/Self ☐ Dependent Spouse* ☐ Domestic Partner* ☐ Dependent Child*

*If the claimant and patient is a dependent, please complete the Dependent Information section below.

Dependent Information

First Name	Last Name	Birthdate (MM/DD/YYYY)	Social Security Number

The remaining sections are to be completed by the claimant's treating physician

Physician Information

First Name	Last Name	Practice Name	
Degree		Medical Specialty	
Address	City	State	Zip Code

Diagnosis Details

Symptoms and Initial Treatment — **Date Symptoms First Appeared** (MM/DD/YYYY) — **Initial Treatment Date** (MM/DD/YYYY)

Primary Diagnosis
Diagnosis (ICD10) — **Date of Diagnosis** (MM/DD/YYYY)
Diagnosis Description

Secondary Diagnosis (if applicable)
Diagnosis (ICD10) — **Date of Diagnosis** (MM/DD/YYYY)
Diagnosis Description

123918 02/2024

Diagnosis Details (continued)

Previous Diagnosis

Has your patient previously been diagnosed with the same or similar condition? ☐ Yes ☐ No

If Yes, please provide dates and a description

Surgery Details

Was Surgery Performed? ☐ Yes ☐ No

Surgery Description

Surgery Date (MM/DD/YYYY)

Treatment Facility Details

Emergency Room	**Admission Date** (MM/DD/YYYY)	**Discharge Date** (MM/DD/YYYY)
Observation Unit	**Admission Date** (MM/DD/YYYY)	**Hours in Observation**
Hospital	**Admission Date** (MM/DD/YYYY)	**Discharge Date** (MM/DD/YYYY)
Intensive Care Unit (ICU)	**Admission Date** (MM/DD/YYYY)	**Discharge Date** (MM/DD/YYYY)
Rehabilitation Facility	**Admission Date** (MM/DD/YYYY)	**Discharge Date** (MM/DD/YYYY)

Questions regarding specific conditions and diagnosis

☐ **Heart Attack**

Did the patient meet 2 of the following criteria?:

	Yes	No
1) Clinical picture of myocardial infarction	☐	☐
2) New EKG findings consistent with myocardial infarction	☐	☐
3) Elevation of cardiac enzymes above standard laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used)	☐	☐

☐ **Sudden Cardiac Arrest**

Did the patient sudden have, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction?

Yes	No
☐	☐

☐ **Coronary Artery Disease with Bypass**

Has it been recommended that the patient undergo a surgical procedure to bypass a narrowing or blockage utilizing venous or arterial grafts?

Yes	No
☐	☐

☐ **Coronary Artery Disease with Coronary Intervention**

Has the patient been diagnosed with heart disease or angina that is treatable with percutaneous coronary intervention (balloon angioplasty, stent implantation or related procedures) to increase the flow of blood through the coronary arteries?

Yes	No
☐	☐

☐ **Heart Valve Disease - Severe**

Date surgery was recommended

Valve being replaced

☐ **Pulmonary Embolism**

Imaging technique performed

☐ **Stroke**

Did the patient have a stroke with neurological impairment, meaning?:

	Yes	No
1) Confirmed by a clinical Diagnosis or neuroimaging study	☐	☐
2) A result of damage to brain tissue caused by either thrombosis, hemorrhage, or embolism	☐	☐
3) Determined by a doctor that neurologic impairment resulted from the cerebral vascular event currently being Diagnosed and was not previously present	☐	☐

☐ **Transient Ischemic Attack** Attach neuroimaging results

Questions regarding specific conditions and diagnosis (continued)

		Yes	No
☐ **Invasive Cancer**			
Patient was diagnosed using:	1) Pathological diagnosis	☐	☐
	2) Clinical diagnosis	☐	☐
	Stage of Cancer **Initial Date of Diagnosis** **Subsequent Date of Diagnosis**		
☐ **Non-Invasive Cancer**			
Patient was diagnosed using:	1) Pathological diagnosis	☐	☐
	2) Clinical diagnosis	☐	☐
	Stage of Cancer **Initial Date of Diagnosis** **Subsequent Date of Diagnosis**		
☐ **Skin Cancer**			
Patient was diagnosed using:	1) Pathological diagnosis	☐	☐
	2) Clinical diagnosis	☐	☐
	Cancer Type ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma		
☐ **End Stage Renal Failure**			
	Has it been determined that a kidney transplant is necessary?	☐	☐
	Does the patient require peritoneal dialysis or hemodialysis?	☐	☐
	Date dialysis begins or began		
	Date surgery was recommended or took place		
	Date patient was placed on the UNOS list		
☐ **Major Organ Failure**			
	Did the patient undergo surgery to receive a liver, lung, entire heart, small intestine, or pancreas?	☐	☐
	If the surgery has not been performed has the patient been placed on the UNOS list for transplant?	☐	☐
	If placed on the UNOS list, please specify the date added		
☐ **Coronavirus**			
	Was the patient confined to a hospital?	☐	☐
	If Yes, how many consecutive days of confinement?		
☐ **Infectious Disease**			
	Was the patient confined to a hospital?	☐	☐
	If Yes, how many consecutive days of confinement?		
	Please specify the type of disease		
☐ **Severe Burns**			
	Do burns cover 20% or more of the body?	☐	☐
	Are burns second degree?	☐	☐
	Are burns third degree?	☐	☐
☐ **Type 1 Diabetes**	Date treatment began		
☐ **Loss of Sight**			
	Is the loss of sight irreversible in both eyes?	☐	☐
	On what date was corrected vision reduced to 20/200 or less in the better eye?		
☐ **Loss of Speech**			
	Has the patient been diagnosed with permanent loss of speech?	☐	☐
☐ **Loss of Hearing**			
	Is the hearing loss irreversible?	☐	☐
	What is the patient's auditory threshold?		
☐ **Coma**	Glasgow coma score ___		

Questions regarding specific conditions and diagnosis (continued)

		Yes	No
☐ **Advanced Dementia**	Attach test results Date requiring physical assistance from another adult to perform 2 ADL's		
☐ **Amyotrophic Lateral Sclerosis**	Attach test results		
☐ **Advanced Parkinson's**	Attach test results		
☐ **Multiple Sclerosis**	Attach test results		
☐ **Bone Marrow/Stem Cell Transplant**	Date of the need for an autologous or allogeneic transplant of bone marrow, necessitated by compromise of the bone marrow's ability to appropriately produce blood cells		
☐ **Bone Marrow/Stem Cell Donation Transplant**	Donation date		
☐ **Severe Mental Illness**	Was the patient confined to a hospital for the treatment of a mental illness?	☐	☐
	Was the patient confined to a hospital for attempting self-harm?	☐	☐
	Did the patient exhibit psychotic features or catatonia?	☐	☐
	Name of condition		
☐ **Significant Mental Illness**	Has the patient missed at least 30 consecutive days at work?	☐	☐
	Name of condition		
☐ **Occupational Hepatitis** Was the Covered Person Diagnosed with Hepatitis B, C and/or D which:	1) is caused by a mucous membrane exposure to blood or bloodstained bodily fluid; and	☐	☐
	2) occurs while the Covered Person was following his or her normal occupational duties; and	☐	☐
	3) is reported by the Covered Person in accordance with the established occupational procedures for such exposures.	☐	☐
	Date of exposure		
	Date of blood test		
☐ **Occupational HIV** Was the Covered Person Diagnosed with HIV which:	1) is caused by a mucous membrane exposure to blood or bloodstained bodily fluid; and	☐	☐
	2) occurs while the Covered Person was following his or her normal occupational duties; and	☐	☐
	3) is reported by the Covered Person in accordance with the established occupational procedures for such exposures.	☐	☐
	Date of exposure		
	Date of blood test		
☐ **Other Congenital Chromosomal Abnormalities**	Type of abnormality		
☐ **Other Congenital Metabolic Disorder**	Type of disorder		
☐ **Other Developmental Delays**	Level of severity		
☐ **Other Structural Defects**	Type of defect		

Physician Signature _____ **Date** (MM/DD/YYYY) _____

OPT IN FOR TEXT ALERTS: If you choose to receive text messages, you agree to receive a one-time text/SMS message as part of the opt-in process. Standard text/SMS rates may apply. Check with your mobile phone carrier.

OPT IN FOR EMAIL ALERTS: If you choose to receive email messages, you agree to receive email communications, sent to the email address provided, as part of the opt-in process and agree to New York Life Insurance Company's privacy policy.

CLICK TO PRINT

Important Claim Notice

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 payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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 Residents: WARNING: It is a crime to 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.

Florida Residents: 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.

Kansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

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.

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.

Maryland Residents: 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania Residents: 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 Residents: **Caution:** 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 by 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. Should aggravating circumstances be 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.

Rhode Island 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.

Tennessee Residents: 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.

Texas 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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents*:* 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.