New York Life Group Benefit Solutions Group Universal Life and Group Variable Universal Life Insurance Claim Form

Important Instructions

GENERAL INFORMATION

1. Please have each beneficiary submit his or her own claim statement.

2. Along with this completed claim form, please include a copy of the insured's Death Certificate.

SECTION 2 - BENEFICIARY INFORMATION

1. Please be sure to describe in what capacity you are making this insurance claim. For example, you may be legally entitled to receive the insurance proceeds because you are the **beneficiary** of the policy, the **guardian of the estate** of the beneficiary, the **assignee** who was assigned the proceeds of this policy, **executor** or the **administrator** of the insured's estate, or the trustee for this policy. Simply list the appropriate term or describe your relationship to the insured in this section.

2. For the following special situations, please note that you will need to provide some additional information.

   a) *If the beneficiary is not of legal age,* please note that a Guardian of the beneficiary's estate must be appointed. The Guardian must then complete the claim form. A copy of the appointment certificate must also be sent in with the claim form.

   b) *If the insurance is payable to the insured's estate,* an Administrator or Executor must be appointed. The Administrator or Executor must then complete the claim form. A copy of the appointment certificate must be sent in with the claim form.

   c) *If the insurance is payable to a trust,* please provide a copy of the Trust Agreement. The Trustee must then complete the claim form.

SECTIONS 3 AND 4 - CLAIMS FOR DEPENDENT BENEFITS AND ACCIDENT DEATH BENEFITS

You will need to complete Section 3 only if you are claiming Dependent Benefits. You will need to complete Section 4 only if you are claiming Accidental Death Benefits.

IMPORTANT REMINDERS

1. Please review all your answers carefully to make sure they are accurate and complete. Then sign and date the form, and return it with all the necessary additional documents in the enclosed prepaid envelope.

   Claim Department
   New York Life Group Benefit Solutions
   P.O. Box 22328
   Pittsburgh, PA 15222-0328

2. Please understand that for the protection of the policy's beneficiaries, New York Life Group Benefit Solutions reserves the right to require or obtain additional information.

Life Insurance Claim Statement

CLEAR FORM

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 last page of this form: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

So that we can process your claim as quickly and efficiently as possible, we ask that you supply the following information about yourself and the Insured. If you have any questions about how to complete this form, please call our Claim Service Center at 1-800-238-2125.

1. INFORMATION ABOUT THE INSURED

INSURED'S NAME _____ DATE OF BIRTH _____ ☐ Male ☐ Female

ADDRESS _____ CITY/STATE/ZIP _____

Insured's Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Civil Union ☐ Domestic Partner

SOCIAL SECURITY # _____ POLICY # _____ CERTIFICATE # _____

INSURED'S EMPLOYER _____ EMPLOYER PHONE # _____

Please list any hospitals, clinics or physicians that treated the deceased during the past three years:

NAME _____ HOSPITAL/PHYSICIAN PHONE # _____

ADDRESS _____ CITY/STATE/ZIP _____

NAME _____ HOSPITAL/PHYSICIAN PHONE # _____

ADDRESS _____ CITY/STATE/ZIP _____

2. BENEFICIARY INFORMATION

BENEFICIARY'S NAME _____ DATE OF BIRTH _____ ☐ Male ☐ Female

ADDRESS _____ CITY/STATE/ZIP _____

TELEPHONE # _____ SOCIAL SECURITY # _____

If the Estate is the Beneficiary, has an Administrator or Executor been appointed or to be appointed? ☐ Yes ☐ No

If Yes, please provide a copy of the appointment certificate with the claim documents or when available.

3. IF CLAIM IS FOR DEPENDENT BENEFITS

DEPENDENT'S NAME _____ DATE OF BIRTH _____ ☐ Male ☐ Female

RELATIONSHIP TO INSURED _____ DEPENDENT'S SOCIAL SECURITY # _____ DEPENDENT'S OCCUPATION _____

DEPENDENT'S EMPLOYER _____ DEPENDENT'S LAST DAY WORKED _____ DEPENDENT'S EMPLOYER TELEPHONE NUMBER _____

If child, ☐ Full-time student ☐ Part-time student

Name and address of school: _____

School Telephone No.: _____ Is this your last eligible dependent child? ☐ Yes ☐ No

4. IF CLAIM IS FOR ACCIDENTAL DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT, ENHANCED ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Please describe the Insured's accident. Include information on how it happened, as well as the date of the accident.

What diseases, illnesses or injuries did the deceased have during the past three years? _____

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

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Disclosure Authorization

GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

Deceased's Name: _____ **Deceased's Date of Birth:** _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning the deceased's health condition, or health history, or regarding any advice, care or treatment provided to the deceased. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice of the deceased's physical or mental condition, or other information concerning the deceased which may be needed to determine policy claim benefits with respect to the deceased. This may also include (but is not limited to) information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. I understand that I may choose whether to receive the results of any laboratory tests or medical examinations performed. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Insured's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the deceased to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning the deceased's occupation, activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used by the Company to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the deceased. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be released to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If the medical information contains information regarding drug or alcohol abuse, I understand that the deceased's records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

I hereby represent that I am authorized to execute this Disclosure Authorization for the release of this information.

Signature of Claimant or
Claimant's Authorized Representative: _____ **Date:** _____

Relationship,
if other than Claimant: _____ Claimant's Date of Birth: _____

"Company" refers to: Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

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IMPORTANT CLAIM NOTICE

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.

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 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.

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.

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.

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.

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