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New York Life Insurance Company
Individual Disability Insurance
1500 Main Street, Suite 1400, P.O. Box 15189
Springfield, MA 01115-5189

Claimant's Statement for New Claim – Individual Disability Insurance

STEP 1 Insured's General information

Name
FIRST | MIDDLE | LAST

Policy number(s)

Date of birth MM/DD/YYYY

Last 4 digits of Social Security number

Address ☐ Check here if your address has changed.
STREET | APT. | CITY | STATE | ZIP

Mailing address *if different*
STREET | APT. | CITY | STATE | ZIP

Preferred phone no.

Please check one: ☐ Cell ☐ Home ☐ Work

Preferred email

STEP 2 Insured's Medical Condition

Please provide medical condition(s) for which the Insured is claiming disability:

Date symptoms began or injury occurred MM/DD/YYYY

Has Insured ever had the same or similar condition? ☐ Yes ☐ No

If yes, please explain:

If accident, describe when and where and how the accident happened.

If accident, was it work-related? ☐ Yes ☐ No

Date Insured was unable to work/perform regular activities MM/DD/YYYY

Please provide any restrictions and limitations which resulted from the medical condition(s):

Has Insured been able to work in any capacity since symptoms began or accident occurred? ☐ Yes ☐ No

If yes, what dates has Insured worked? FROM MM/DD/YYYY TO MM/DD/YYYY

Please explain where Insured was working and what job they were performing:

When is Insured expected to return to his/her regular work? MM/DD/YYYY

Is the Insured currently able to drive? ☐ Yes ☐ No

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STEP 3 Employment Information *(at the time disability began)*

Please check one: ☐ Employed ☐ Self-employed ☐ Unemployed

3A. Employment Information

Company/ Employer name	Dates employed FROM TO
Address STREET APT. CITY STATE ZIP	
Company/Employer contact name and title	Company/Employer contact phone number
Insured's occupation/ job description	
Number of hours worked per week	Monthly earned income Prior to disability $ Current income $
Does the Insured's employer pay all or part of their disability policy? ☐ Yes ☐ No	If yes, what percentage of the Insured's Individual Disability Income Insurance policy does the employer pay? %
Briefly describe the Insured's daily activities prior to the medical condition(s).	

3B. If Self-Employed *(Complete Sections A and B)*

Is the business operating at this time? ☐ Yes ☐ No If no, what date did business dissolve? MM/DD/YYYY

Business type: ☐ Sub Chapter "S" Corporation ☐ Sole Proprietor ☐ Partnership ☐ "C" Corporation

Has Insured hired any employees to perform their previous job? ☐ Yes ☐ No

Insured's current job title

Insured's current role with this company

3C. Insured's Previous Employer

Company/ Employer name	Dates employed MM/DD/YYYY FROM TO
Address STREET CITY STATE ZIP	
Company/Employer contact name and title	Company/Employer contact phone number
Duties/ responsibilities	

STEP 4 Insured's Medical Providers/Treatment

Please provide name(s), address(es) and telephone number(s) of all physicians (past and present) who have treated the Insured for the medical condition(s) identified in Step 2. *(Attach additional sheet if necessary)*

Name	Phone
Address STREET CITY STATE ZIP	
Dates of treatment MM/DD/YYYY FROM TO	Please explain what treatment was for:

Name	Phone
Address STREET CITY STATE ZIP	
Dates of treatment MM/DD/YYYY FROM TO	Please explain what treatment was for:

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STEP 4 Insured's Medical Providers/Treatment *(continued from previous page)*

If Insured was hospitalized for the specified medical condition(s), please provide the information below:

Hospital name	Dates of hospitalization MM/DD/YYYY FROM TO
Address STREET CITY STATE ZIP	Hospital phone number

Hospital name	Dates of hospitalization MM/DD/YYYY FROM TO
Address STREET CITY STATE ZIP	Hospital phone number

Please list all prescribed medications Insured is taking *(attach additional sheet if necessary)*:

Medication name	Condition treated
Prescribing physician	Pharmacy name

Medication name	Condition treated
Prescribing physician	Pharmacy name

Medication name	Condition treated
Prescribing physician	Pharmacy name

STEP 5 Insured's Other Income & Benefits

Is Insured currently receiving any income from other sources? ☐ Yes ☐ No If yes, check all that apply:

SOURCE	DATE APPROVED	COMPANY/POLICY NO. *if applicable*	BENEFIT AMOUNT
☐ Self-employment	N/A	N/A	N/A
☐ Social Security Disability		N/A	
☐ Social Security Retirement		N/A	
☐ Short-term/Long-term Disability			
☐ Workers' Compensation			
☐ Other *(please specify)*			

The Insured may also submit a copy of supporting documentation (Workers' Compensation, Social Security Notice of Decision, VA Rating, etc.) Please be advised that New York Life does not rely solely on decisions made by the Social Security Administration or any other disability insurer, state disability, or any other government program.

STEP 6 Signature

To expedite consideration of the claim, please fully and completely answer each question, sign and date all forms and attachments and return the originals to us. Failure to complete all questions or to sign and date the claim form(s) or authorization may result in a delay in the consideration of the claim.

In furnishing this form, the Company does not admit the validity of this claim or waive any of its rights or defenses. Eligibility for benefits will be determined in accordance with the terms of the specific policy contract(s) with us.

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 five thousand dollars and the stated value of the claim for each such violation. Please refer to the enclosed page entitled STATE VARIATIONS OF FRAUD WARNINGS for specific notices required in certain jurisdictions.

DECLARATION AND SIGNATURE: I declare that the answers provided on each page of this form and any attachments are complete and true to the best of my knowledge and belief. I understand that the Company reserves the right to require further information in order to evaluate the claim.

X

Signature of Insured/Authorized Representative (Insured or Insured's Authorized Representative*) Date

X

Authorized Representative Title or Relationship* Date

* If the Insured is incapable of completing the form, the Insured's legal representative (i.e. a Guardian or Attorney-In-Fact under a Power of Attorney) may complete the form. A copy of the legal guardianship, P.O.A. papers or other documentation naming the authorized representative must be included with the form.

STEP 7 Done! Send us your completed form.

Mail: **New York Life, Individual Disability Insurance, 1500 Main Street, Suite 1400, P.O. Box 15189, Springfield, MA 01115-5189**
Fax: **1-(833) 963-3462** Email: **IDIClaims@IDI.newyorklife.com** Questions? Call us at (844)-420-1391