Dear Claimant:

We are sorry to learn of your unfortunate illness. 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,

Kathleen Scollan
Vice President and CFO
Arizona Fraud Warning
For your protection Arizona law requires the following 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 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 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 Fraud Warning
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.

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.

Maryland Fraud Warning
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and may be subject to fines and confinement in prison.

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 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 with the penalty of 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. If aggravating circumstances are 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.

Virginia Fraud Warning
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.

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.
Insured Statement

Insured Information

Insured Name ___________________________ Group Number ___________________________

Address __________________________________________ Social Security No. ___________________________

Telephone Number ( ) ____________

Date of Birth ____________ Month Day Year

Disability Information

Specify nature of the disability ________________________________________________

If sickness, when did symptoms first appear? ____________________________________________

If injury, describe When, Where and How accident occurred. ____________________________________________

Occupation and duties at time of Disability ____________________________________________

From what date do you claim that total disability has prevented you from performing your occupation?

From what date do you claim that total disability has prevented you from performing any occupation?

If now totally disabled, when do you expect to be able to return to work?

If not now totally disabled, on what date did total disability terminate?

Have you applied for Social Security Disability benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Have you applied for Veteran Administration benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Have you been approved for any other disability benefits? ☐ Yes ☐ No If yes, attach Award/Denial Letter

Insured Signature

I have read and understand the Fraud Statement that is applicable to the state in which I reside. New York 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 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.

Insured Signature ___________________________ Date ___________________________
MEDICAL INFORMATION:

Please provide the names and addresses of all physicians and hospitals who treated the insured within the last ten (10) years. If necessary, use a separate sheet of paper.

<table>
<thead>
<tr>
<th>Doctor/Hospital Name</th>
<th>Address, City, State, Zip Code</th>
<th>Telephone Number</th>
<th>Dates</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
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I give my permission to release information to New York Life including its agents, parent or subsidiary companies and attorneys, reinsurers, insurance support groups and independent administrators who are acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use, other insurance coverage, financial and employment history. Medical professionals or facilities, pharmacies, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators, may release this information. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. Either I, or a person I choose, may request a copy of this authorization. This authorization is valid for 24 months from the date signed until the claim is resolved.

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**Insured Signature**

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**Date**

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*Return this Claim Form to the address the Plan Administrator provided to you.*
**Insured Information**

<table>
<thead>
<tr>
<th>Insured Name</th>
<th>Employer Name</th>
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<table>
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<tr>
<th>Date of Birth</th>
<th>Social Security No.</th>
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<tbody>
<tr>
<td>Month Day Year</td>
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</table>

**Note to Physician:** Any fee for completing this form is not chargeable to New York Life Insurance Company and should be collected from the patient.

**Disability Information**

**History**

When did symptoms first appear or accident happen?  

Date patient ceased work because of disability?  

Has patient ever had the same or similar conditions?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>If yes, explain:</th>
</tr>
</thead>
</table>

Is condition due to injury or sickness arising out of patient’s employment?  

Name and addresses of other treating physicians:  

Did another practitioner refer the Patient to you?  

| YES | NO | If yes, provide names and addresses: |

**Diagnosis**

Current Medical Condition(s)

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>ICD-9 CM Code</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
<th>ICD-9 CM Code</th>
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Objective finding (including X-Ray, EKG’s, Laboratory Data and any clinical finding)  

**Dates of Treatment**

<table>
<thead>
<tr>
<th>Dates of Treatment</th>
<th>Date of Last Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of First Visit</td>
<td></td>
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<tr>
<td>Frequency of Visits</td>
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<tr>
<th>Nature of Treatment</th>
<th>(Including surgery and medications prescribed, if any)</th>
</tr>
</thead>
</table>

**Progress**

Has patient    

<table>
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<tr>
<th>Recovered</th>
<th>Improved</th>
<th>Unchanged</th>
</tr>
</thead>
</table>

Is patient    

<table>
<thead>
<tr>
<th>Ambulatory</th>
<th>House Confined</th>
<th>Bed Confined</th>
</tr>
</thead>
</table>

Has patient been hospital confined?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If Yes, Confined Dates</th>
</tr>
</thead>
</table>

Name and Address of Hospital  

**Cardiac**

Functional capacity  

<table>
<thead>
<tr>
<th>Class 1 (No Limitations)</th>
<th>Class 2 (Slight Limitations)</th>
</tr>
</thead>
</table>

(American Heart Association)  

Blood Pressure (last Visit)  

<table>
<thead>
<tr>
<th>Class 3 (Marked limitations)</th>
<th>Class 4 (Complete Limitations)</th>
</tr>
</thead>
</table>
**Mental/Nervous Impairment** (if applicable)

Define “stress” as it applies to the claimant

What stress and problems in interpersonal relations has claimant had on job?

- [ ] Class 1: Patient is able to function under stress and engage in interpersonal relations. (No Limits)
- [ ] Class 2: Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight Limits)
- [ ] Class 3: Patient is able to function in only limited situations and engage in limited interpersonal relations. (Moderate Limits)
- [ ] Class 4: Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked Limits)
- [ ] Class 5: Patient has significant loss of psychological, personal and social adjustments. (Severe Limits)

**Physical Impairments** (*as defined in Federal Dictionary of Occupational Titles)

- [ ] Class 1: No limits of functional capacity, capable of heavy work* No Restrictions (0-10%)
- [ ] Class 2: Medium manual activity* (15-30%)
- [ ] Class 3: Slight limitations of functional capacity; capable of light work* (35-55%)
- [ ] Class 4: Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- [ ] Class 5: Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

**Prognosis**

Is patient now totally disabled from present job? □ Yes

What duties of patient’s job is he/she incapable of performing?

Can present job be modified to allow for handling with impairment? □ Yes

Is the patient disabled from all other jobs? □ Yes

Do you expect a fundamental or marked change in the future? □ Yes

If yes, explain

If yes, when will patient recover sufficiently to perform duties of any job?

When will patient recover sufficiently to perform duties of any job?

**Rehabilitation**

Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary, speech, etc.) □ No

When could trial employment commence? Patient’s Job [Month Day Year] Full Time □ Part Time □

Any Other Work [Month Day Year] Full Time □ Part Time □

Would vocational counseling and/or retraining be recommended? □ Yes □ No

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

Attending Physician Name (Please Print) ________________________________ Degree ____________________ Telephone Number ____________________

Address ____________________ City ____________________ State ____________________ Zip Code ____________________

**Physician Signature** ____________________ Date ____________________