New York Life Insurance Company
Group Membership Association Claims

Life & Health Group Administrator
1100 Virginia Drive, Suite 250
Fort Washington, PA 19034

Dear Beneficiary:

Please accept our condolences on your recent loss. We understand this is a difficult time, and we hope that we can alleviate any concerns you may have about your claim.

To help process your claim in the fastest possible manner, New York Life Insurance Company is providing this easy to use Claim Form for your convenience. Please review the form in its entirety, and then follow the step-by-step instructions to submit your claim.

New York Life Insurance Company prides itself on the speed with which it pays claims. Most claim payments are sent to the beneficiaries within ten business days from the date the Company receives the completed Claim Form, death certificate and other documents as appropriate to the claim.*

Please be assured that New York Life will act as quickly as possible to complete the processing of your claim once we receive all the necessary information and documentation. Please feel free to contact your plan administrator, if you have any questions.

Sincerely,

Kathleen Scollan
Vice President and CFO

CLAIM FORM FOR ACCIDENTAL DEATH BENEFITS

Return Completed Forms to:

Life & Health Group Administrator
1100 Virginia Drive, Suite 250
Fort Washington, PA 19034

*This claim form may have been sent before New York Life has determined whether any insurance was in force at the time of death, and to whom the proceeds are payable. New York Life retains the right to make such determination.

HOW TO COMPLETE YOUR CLAIM FORM

Please read this before you start to complete your Claim Form

Upon notice of the death of the insured, the Plan Administrator generally begins gathering information for your claim. To process your claim, we must have a fully completed Claim Form from each beneficiary, one certified copy of the death certificate and other documents as appropriate to the claim. You may use a photocopy of the Claim Form if there is more than one beneficiary.

No original documents will be returned.

GROUP CERTIFICATE INFORMATION

Please be sure to enter all certificate numbers on the Claim Form and enclose all the original insurance certificates, if available. If not available, please explain. If the death is due to an accident or your insurance plan includes an Accidental Death benefit, it is important that you send us additional information such as a coroner's report and newspaper articles, and that you sign the Medical Authorization to avoid delay.

DECEASED INFORMATION

Information about the deceased is necessary for purposes of identification and to help us determine if any special benefits that may have been purchased by the insured are also payable.

BENEFICIARY STATEMENT & MEDICAL INFORMATION AND AUTHORIZATION

Please complete this section if full since the claim is for an Accidental Death and read the release of Medical Information and Authorization.

Taxpayer Identification Number: In nearly all cases, life insurance benefits are not subject to income tax. However, New York Life pays interest on all proceeds from the date of death.

The Federal government requires us, and all other financial institutions, to report interest we pay you. Therefore, we are required to obtain your Social Security Number or Taxpayer Identification Number, which you must certify under penalties of perjury. If you are applying for a tax number, please write, "applied for" in the appropriate space. If you fail to supply us with an identification number, the Federal government requires us to withhold a portion of your interest as a deposit against the taxes that may be due.

Some persons have been notified by the Internal Revenue Service that they are subject to "backup withholding" because in the past they did not report all their interest or dividends. If you have been so notified, and a backup withholding order has not been rescinded, you must check the Backup Withholding statement right below your Social Security or Taxpayer Identification Number. We may contact you for more information if there are any questions about your Taxpayer Identification Number or backup withholdings status, or if you are a non-resident alien or foreign entity.

- Claims by an Estate: If an Executor or Administrator is filing the claim, he or she must sign the Claim Form and submit a certified copy of the appointment papers. Be sure to use the Tax Identification Number of the Estate. Note: A Last Will and Testament will not be accepted as proof of authority of executorship.
- Assignment: If you have assigned all or any portion of the claim to a funeral home for final expenses, please include a copy of that assignment. If the deceased assigned the policy proceeds to a bank or other financial institution, an authorized representative of that institution must sign the Claim Form.
- If the Beneficiary is a Minor: If there is a legal guardian for a minor, he or she should sign the Claim Form and submit a copy of the court document appointing the custodian of the minor child's property/estate. If no legal guardian has been appointed, payment may be considered under the Uniform Transfers to Minors Act (UTMA) subject to state guidelines. Please contact our office for further information.

YOUR SIGNATURE

Please sign the Claim Form, which includes the authorization to release the deceased's medical information.

Illinois Interest Statement

If the certificate was issued in Illinois, you will be paid 10% interest, from the date of death, if your claim is not paid within 31 days of receiving the necessary proof needed to settle the claim.

State Variations of Fraud Warnings

Please refer to the applicable fraud warnings for your state of residence.

Arizona: 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: 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: 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: 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: 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: 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.

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

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.

Oregon: 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 may be subject to prosecution for insurance fraud. Any person who provides misinformation material to the content of the contract, which is relied upon by the insurer, and which is either material to the risk assumed by the insurer or provided fraudulently, may be subject to the denial of insurance benefits.

Pennsylvania: 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: 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. 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.

Virginia: 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 or denial of insurance benefits.

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.

ACCIDENTAL DEATH CLAIM FORM *Please type or print clearly.*
Please return this Claim Form together with a certified copy of the death certificate and any other documentation required to the address the Plan Administrator has provided to you.

LIST ALL GROUP CERTIFICATES FOR YOUR CLAIM

Are the Group Certificates attached? ☐ Yes ☐ No If no, please explain ☐ Lost Other

Please complete the Medical Information and Authorization and send us copies of a police report, coroners report, any newspaper articles and any other documentation to support your claim for Accidental Death Benefits.

DECEASED INFORMATION

Name:

List all other names by which the deceased was known:

Date and time of death:

Date and time of accident:

Describe accident in detail:

If automobile accident, was insured: ☐ Driver of Vehicle ☐ Passenger ☐ Pedestrian

Was accident reported to police or other official agency? ☐ Yes ☐ No

If "Yes" give name and address of department or agency

Was an autopsy performed? ☐ Yes ☐ No Autopsy Performed By:

Address (street, city, state, zip code)

BENEFICIARY STATEMENT & MEDICAL INFORMATION AND AUTHORIZATION

Name:
First *Middle* *Last*

Address:
Street *City* *State* *Zip Code*

Home Phone: ( ) Alternate Phone: ( )

Date of Birth: Email Address:
Month *Day* *Year*

Social Security or Taxpayer Identification Number:

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other

Relationship to Deceased: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Please list the insured's family doctor as well as the names, addresses and telephone numbers of all physicians, clinics and hospitals that treated the insured for the accident. If necessary, use a separate sheet of paper. This sheet must be signed and dated.

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

MEDICAL AUTHORIZATION:

I give my permission to release information concerning _____ who died on _____
Name of Insured

to New York Life Insurance Company including its agents, affiliates or subsidiary companies and attorneys, reinsures, insurance support groups and independent administrators who are acting on their behalf ("New York Life"). 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, driving records, or information otherwise needed to determine policy claim benefits due, but excludes psychotherapy notes. This information may be released by medical professionals or facilities, pharmacies, pharmacy-related service organizations, prescription history database suppliers, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators, any consumer reporting agency, the Social Security Administration, the Internal Revenue Service, the Veteran's Administration, or any other organization or person having any knowledge of the above named Insured. When requesting information from any of the sources named above, a copy of this form is as valid as the original. I am aware that any information obtained will be used to evaluate my claim. I understand that my claim will not be processed unless this authorization is completed and signed. Either I, or a person I choose, am entitled to receive a copy of this authorization. This authorization is valid from the date signed until the claim is resolved, except in those states that allow for only a one-year limit.

I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on this authorization. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to insurance regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing this authorization.

Your Signature

I have read and understand the fraud warning in the "State Variations of Fraud Warnings" 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.

Under penalties of perjury, I certify: (1) my social security number or Tax ID number shown on this form is my correct taxpayer identification number, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding, (3) I am a U.S. person (includes a U.S. resident alien), and (4) I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

☐ Check this box if the IRS has notified you that you are subject to backup withholding.

If I am not a U.S. citizen, U.S. resident alien or other U.S. person, I am submitting the applicable Form W8 with this form to certify my foreign status and, if applicable, claim treaty benefits.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature (Required) *Date*