New York Life Insurance Company
Group Membership Association Claims

Program Administrator
Hagan Insurance Group
PO Box 1889
Sioux Falls, SD 57101

Dear Claimant:

We are sorry to learn of your 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

CLAIM FORM FOR ACCELERATED DEATH BENEFITS

Return Completed Forms to:

Hagan Insurance Group
PO Box 1889
Sioux Falls, SD 57101

HOW TO COMPLETE YOUR CLAIM FORM

Please read this page before you start to complete your Claim Form.

Important Notice:

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Prior to applying for accelerated death benefits certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax adviser.

Premiums continue to be payable on the coverage after acceleration.

Insured Statement

Information about the insured is necessary for purposes of identification and benefit determination. Please be sure to complete the form in its entirety and be certain to indicate the address you want all future correspondence to be mailed.

Attending Physician Statement

This from must be fully completed by your attending physician. (In the state of Connecticut, it may be completed by a physician or an advanced practice registered nurse.)

Certificateholders Statement

Please sign and date this section. If you have previously listed an irrevocable beneficiary or collateral assignee, they must also sign this form.

NOTE:
It is our desire to process your claim as quickly as possible. Before submitting your claim form, please review the entire form to be sure all information is complete.

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: A 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.

ACCELERATED DEATH BENEFIT CLAIM FORM
Insured Statement

Insured Name _____ Group Number _____

Address _____ Social Security No. _____

_____ Date of Birth _____
Month Day Year

Telephone Number ( ) _____

Nature of Illness _____ Are you totally disabled? Yes ☐ No ☐

If yes, date of total disability _____
Month Day Year

Please provide the names, addresses and telephone numbers of all physicians, hospitals or other medical sources who treated you within the last ten (10) years, being sure to list your family doctor in the first space provided. If necessary, use a separate piece of paper.

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

I give my permission to release information to New York Life Insurance Company including its agents, affiliates or subsidiary companies and attorneys, reinsurers, 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 judge 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.

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.

_____ _____
Insured Signature *Date*

_____ _____
Owner's Signature (if owner is different than insured) *Date*

Massachusetts Residents Only: Accelerated benefit is available only on amounts in force before January 1, 2000

ACCELERATED DEATH BENEFIT CLAIM FORM
Attending Physician Statement

Insured Name _____ Social Security Number _____

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

We are particularly interested in significant history findings, diagnoses and treatment at the time this patient was diagnosed with their terminal illness. This information will be held confidential and privileged.

Diagnosis _____ Date Diagnosed _____
Month Day Year

Describe treatment or operation _____ Date of last visit _____
Month Day Year

Is the patient totally disabled from his/her OWN occupation? Yes ☐ No ☐ If yes, date total disability began _____
Month Day Year

Is the patient totally disabled from ANY occupation? Yes ☐ No ☐ If yes, date total disability began _____
Month Day Year

Please check the one which best indicates your estimate of the patient's life expectancy

☐ 12 Months or Less ☐ 13 to 18 Months ☐ 19 to 24 Months ☐ More than 24 months

Briefly describe significant medical findings to document prognosis:

_____

Have any other physicians or surgeons been consulted? ☐ Yes ☐ No

If yes, please give their name, date and nature of treatment:

_____

Did another doctor refer the patient to you? ☐ Yes ☐ No

If yes, please provide their name, address and telephone number:

_____

( )

Attending Physician Name (Please Print) Degree Telephone Number

Address City State Zip Code

Physician Signature Date
(In Connecticut, may also be signed by an advanced practice RN.)

New York Life Insurance Company
Group Membership Association Claims

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

CERTIFICATEHOLDER'S STATEMENT

I am the certificateholder under the group policy stated on the claim form. As such, I make this voluntary application to accelerate benefits without coercion on the part of any third party.

I certify that I have received the illustration of what my Accelerated Benefits are and the impact it will have on my certificate.

I further understand that no health care facility can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such a facility.

NOTE – NEW YORK RESIDENTS: I acknowledge that New York Life is prohibited from paying the Accelerated Benefits for a period of 5 days from the date on which the illustration is sent to me. I further understand that no health care facility, as defined in Section 20 of the Public Health Law, can require a person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Insured Signature _____ Date _____

Owner's Signature (if owner is different than insured) _____ Date _____

TO BE COMPLETED BY IRREVOCABLE BENEFICIARY(IES) AND/OR ASSIGNEE(S)
(IF CURRENTLY DESIGNATED)

Irrevocable Beneficiary/Assignee Signature _____ Date _____

Irrevocable Beneficiary/Assignee Name (PLEASE PRINT) _____

Irrevocable Beneficiary/Assignee Signature _____ Date _____

Irrevocable Beneficiary/Assignee Name (PLEASE PRINT) _____