New York Life Insurance Company
Group Membership Association Claims
PO Box 30782
Tampa FL 33630-3782
(800)792-9686

Dear Claimant:

We are sorry to learn of your unfortunate situation. We understand this is a difficult time, and we hope that we can alleviate any concerns you may have about your claim.

We have designed this special Claim Form to simplify and speed the claim process. Please complete the Insured Information, have your doctor complete the Physician Statement, and attach your hospital bill to this claim form.

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 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. If you have any questions, please contact us at 1-800-792-9686. Representatives are available between the hours of 8 a.m. to 4 p.m. (Eastern Time) Monday through Friday.

Sincerely,

Tina Brengle

Tina Brengle
Corporate Vice President

Claim Form For Hospital Accident Confinement Benefit

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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 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.

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.

Hospital Accident Confinement Claim Form

PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM
No original documents will be returned.

Insured Information

Insured Name ______________________ Group Number ______________________

Member Name ______________________ Relationship ______________________

Address ______________________ Social Security Number ______________________

Telephone (   ) ______________________ Date of Birth ______________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If claim is for Dependent Child, when charges were incurred, was the child: Married? ☐ Yes ☐ No

Employed? ☐ Yes ☐ No If Yes, please indicate Employer Name ______________________

Accident Information

Date of Accident ______________________ Place of Accident ______________________
Month Day Year

Occupation at the time of Accident ______________________

Date last worked full time ______________________ Date first consulted your doctor ______________________
Month Day Year *Month Day Year*

Describe fully how the accident occurred, the nature of injuries received, and loss(es) for which claim is made.

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____

Did the loss arise out of, or in the course of your employment, or any employer? ☐ Yes ☐ No

Medical Information

Doctor/Hospital Name	Address, City, State, Zip Code	Telephone Number	Dates of Confinement To-From

Insured Certification

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.

I certify that the information shown above is complete and accurate.

______________________ ______________________
Insured Signature **Date**

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

Authorization For Release of Information (Completed by Insured)

I give my permission to release information to New York Life Insurance Company including its agents, parent 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 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, which 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 agency. In this case, the information may no longer be protected by the rules governing this authorization.

Insured Signature ______________________ **Date** __________

Physician Statement (must be completed in full by provider of service)

Name of Patient ______________________

Nature of Injury ______________________

Date of Injury ______________________
Month *Day* *Year*

Diagnosis & ICD9 Code 1. __________ 2. __________

How did the injury occur? ______________________

Date first consulted you for this condition ______________________
Month *Day* *Year*

Was the patient confined to a hospital as a result of the injury? ☐ Yes ☐ No If yes, please name facility

Hospital or facility name, address and telephone number ______________________

Dates of Hospital Confinement __________ Through __________
Month *Day* *Year* *Month* *Day* *Year*

Has the Patient ever had same or similar symptoms? ☐ Yes ☐ No

If yes, give first date __________
Month *Day* *Year*

Attending Physician Name (Please Print) ______ Degree ______ Telephone Number ( )

Address ______ City ______ State ______ Zip Code ______

Physician Signature ______________________ **Date** __________