NEW YORK LIFE GROUP BENEFIT SOLUTIONS

CLEAR FORM

MAIL COMPLETED FORM TO: New York Life Group Benefit Solutions
Pittsburgh Claim Service Center
P.O. Box 22326
Pittsburgh, PA 15222-0326
Toll Free #: 1.800.238.2125 Fax #: 877.300.6770

Group/Association - Total and Permanent Disability / Waiver of Premium

NEW YORK 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***Arizona, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

SECTION TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

Name of Employee / Association Member *(Last Name) (First Name) (Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Address *(Street) (City) (State) (Zip Code)* | Telephone #

Insured's Marital Status ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced

Occupation *(Please attach a copy of the employee's Job Description)*

Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

Please check the appropriate blocks regarding the insured's employment status.

☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time
Hrs./Wk. _____

Basic Annual Earnings $ | Date Hired/Member of Association | Date of Last Change in Earnings | Date of Last Increase in Benefits

Date Last Worked | Number of Hours Worked | Effective Date of Insurance | Premium Paid Through Date

Percentage of Employee Contribution Towards Premium % | Employee's Contribution were made on ☐ Pre-tax or ☐ Post-tax Basis

Policy No. | Amount of Insurance $

Division

Has Employee's / Member's Coverage Terminated? ☐ Yes ☐ No **DATE(S)** **REASON**

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

Name of Employer / Association | Division | E-Mail Address

Address *(Street) City (State) (Zip Code)* | Telephone #

Authorized Representative
PRINT: SIGNATURE: | Date

TO BE COMPLETED BY THE EMPLOYEE / ASSOCIATION MEMBER

What was the last day you were able to work due to your disability? | E-Mail Address | Did you apply for conversion of your Group Policy? ☐ Yes ☐ No If "yes", please provide policy number and effective date:

Name other sources of income to which you and your dependents are entitled by checking the appropriate sources listed below. Please indicate below the current status of Social Security Disability/Retirement benefit (check appropriate status). If you are receiving Social Security benefits, please provide us with a copy of the most recent decision (Award or Denial).

☐ Social Security
☐ Awarded ☐ Denied/No appeal has been filed ☐ Denied/Filed for Reconsideration ☐ Denied/At Administrative Law Judge Level
☐ Other (Comments) _____

☐ Pension ☐ Governmental ☐ Worker's Compensation _____ (Identify Insurance Carrier) _____ (Policy Number)
☐ Disability Insurance _____ (Identify Insurance Carrier) _____ (Policy Number)

Describe in your own words what is wrong with you. (If accident, describe circumstances)

TO BE COMPLETED BY THE EMPLOYEE / ASSOCIATION MEMBER *(Cont'd)*

EDUCATION

Level of Education Completed: (circle one)
1 2 3 4 5 6 7 8 9 10 11 12

High School Diploma ☐ Yes ☐ No

G.E.D. ☐ Yes ☐ No

Vocational, Business or Correspondence School (name, address, courses)

Name: _____ Name: _____

Address: _____ Address: _____

Courses: _____ Courses: _____

Certificates or Special Licenses: _____

College Education Completed: (circle one)
1 2 3 4 5 6

Major(s)

Degree(s)

U.S. Military or Naval Science ☐ Yes ☐ No

If Yes, Special Training

WORK HISTORY

Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary $
Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary $
Employer		Address
Date Started	Date Left	Reason
Job Title	Job Duties	Salary $

MEDICAL HISTORY

Names of all attending physicians consulted for the disability from the last day worked to the present time.

Name		Address		
Telephone Fax		Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address		
Telephone Fax		Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No
Name		Address		
Telephone Fax		Treatment Period(s)	Type of Treatment(s)	Currently Treating You? ☐ Yes ☐ No

Names of hospitals | Complete Address | Date entered - Date discharged

Please provide the Name of your Medical Insurance Carrier _____

Are you able to take care of all your personal care needs (grooming, dressing, etc.). If no, what areas require assistance?

_____

_____

Please indicate the chores you perform on a regular basis (check all that apply)

☐ Cooking ☐ Shopping ☐ Laundry ☐ Cleaning ☐ Child Care ☐ Yard Work, Gardening ☐ Other _____

Do you go for walks? ☐ Yes ☐ No If yes, how often and how far to you walk? _____

EMPLOYEE'S / ASSOCIATION MEMBER'S CERTIFICATION

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature of Employee / Association Member | Date Signed

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

Disclosure Authorization

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Claimant's Name: _____

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; New York Life Group Insurance Company of NY (Life Insurance Company of North America and New York Life Group Insurance Company of NY shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide its services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature) _____ (Date Signed) _____

(Print Name) _____ (Date of Birth) _____

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

ELECTRONIC COMMUNICATIONS DISCLOSURE AND CONSENT

Please read this information carefully. Then, print and keep a copy for yourself.

As a valued New York Life Group Benefit Solutions (NYL GBS) customer, we send you information about your benefits through the mail. This information may include:

- Claim forms, authorizations, disclosures, affidavits, electronic funds transfer agreements, privacy notices, and letters letting you know about changes to any of these items
- Claim status updates letting you know that we've received a claim, or that we've updated the status of a claim
- Letters asking you, or someone else, for additional information to help with the review of a claim.

Did you know that you may also give us consent to send you this information electronically?
NYL GBS has an easy to use secure email encryption tool that allows us to communicate with you electronically. All you need is a computer, internet access, and a personal email address (called a Designated Email).

By giving us your consent, you understand you may no longer receive information in paper form and you accept responsibility for promptly reviewing the secure emails you receive. This ensures you can take appropriate action so that any benefits you are eligible for are not delayed or that any rights you have are not affected. If downloading communications from a secure portal, delivery of information sent to you is deemed complete once all of data comprising the information has been uploaded to our secure web portal. If receiving communications by secure email, delivery of information sent to you is deemed complete once all data comprising the information has been received by the email server of the system used to provide your Designated Email.

What do I need to know before I give my consent?

Access to Paper Copies

At any time, you can still request paper copies of information. Simply email us from your valid Designated Email, call or send us a letter by mail to: **New York Life Group Benefit Solutions, P.O. Box 22328, Pittsburgh, PA 15222-0328**

We keep copies of the information we email for the time periods required by law. We recommend saving or printing copies of the information you get electronically to ensure you have it when you need it.

System Requirements

To use the NYL GBS secure email tool, access messages, and keep copies of the information we send, you must have a working, personal Designated Email address and a computing or communications device with:

- Working Internet access
- Web browser that supports 128-bit encryption (such as Chrome®, Firefox®, Microsoft Edge® , or Safari®),
- 16 MB of available memory (32 MB of RAM recommended) and
- Program that can view, save and print PDF files (such as Adobe® Reader® 4.0 or higher).

Our Right to Send Paper

We have the right to send you information through the mail even if you agreed to receive it electronically. For example, we may send you a letter through the mail if we have a system outage, if we suspect fraud, if for any reason your Designated Email does not accept emails from us, or if we receive notification that you have not opened your email messages.

Modification of Consent Terms

We reserve the right to modify (change) these terms and conditions if we choose. We will provide you with notice of a modification electronically, and the date it is to go into effect. If you do not agree to the new terms and conditions in the notice, you may provide your Withdrawal of Consent before the effective date. Failure to withdraw your consent, or follow the instructions in the notice, lets us know that you agree to the new terms.

Please review and keep for your records.

Withdrawal of Consent

Your consent remains in effect until you tell us otherwise and provide a Withdrawal of Consent. You may withdraw your consent at any time if you decide you want to go back to paper information. To contact us, you may email using the same valid, personal e-mail address you used to register for secure emails, call, or send us a letter by mail (See office address above).

Withdrawing your consent will let us know that you want to stop receiving secure emails. It will not change the outcome of any information we have already sent you.

Your Consent

Please read the following paragraph, make your selection, print and sign your name, enter the date, give us your email address.

By signing my name below, I agree that I have read the information about the NYL GBS secure email tool and I wish to receive information electronically from NYL GBS. I also agree that:

1. I have technology that meets the System Requirements highlighted above.
2. I have received written instruction on how to receive and manage messages using the email tool.
3. I will provide and maintain a valid Designated Email and verify that this email belongs to me. I agree to notify GBS of any changes to my Designated Email, including the email address itself, by calling or sending a letter through the mail. (See office information listed above).
4. I understand that NYL GBS may only send me information electronically from this point forward unless I withdraw my consent.
5. I understand that the date my signature is affixed below is the effective date of my consent.

If NYL GBS does not receive your signed Consent, NYL GBS will continue to send paper communications. If you do not wish to receive information electronically from NYL GBS, do not sign or return this form to NYL GBS.

Select One:

☐ I consent to receive information electronically for ALL claims for which I may be eligible for benefits.

Name: _____ **Email Address:** _____

(Please print clearly) *(Please print clearly)*

Signature: _____ **Date:** _____

Employee Name: _____ **Employee Date of Birth:** _____

Please review and keep for your records.

CLICK TO PRINT

IMPORTANT CLAIM NOTICE

Arizona Residents: 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 Residents: 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 Residents: 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 Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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.

Kansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana Residents: 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.

Maryland Residents: 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania 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 subjects such person to criminal and civil penalties.

Puerto Rico Residents: **Caution:** 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 by 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.

Rhode Island Residents: 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.

Tennessee Residents: 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.

Texas Residents: 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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents*:* 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.