New York Life Insurance Company
Group Membership Association Claims
1200 E. Glen Ave.
Peoria Heights, IL 61616

AVMA | LIFE
Veterinarian Inspired Coverage
Underwritten by NEW YORK LIFE

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 Physicians Statement.

Please feel free to contact your Plan Administrator, if you have any questions.

Sincerely,

Kathleen Scollan
Vice President and CFO

CLAIM FORM FOR GROUP WAIVER OF PREMIUM BENEFITS

This claim form may have been sent before New York Life has determined whether any insurance was in force at the time of disability. New York Life retains the right to make such determination.

State Variations of Fraud Warnings

Kindly 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.

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.

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.

WAIVER OF PREMIUM BENEFIT CLAIM FORM
Insured Statement — Form 1W

No original documents will be returned

INSURED'S STATEMENT

Name: _____ Group No: _____

First *Middle* *Last*

Address: _____

Street *City* *State* *Zip code*

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 <u>your</u> occupation? _____

Month *Day* *Year*

From what date do you claim that total disability has prevented you from performing <u>any</u> occupation? _____

Month *Day* *Year*

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

Month *Day* *Year*

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

Month *Day* *Year*

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 warning in the "State Variations of Fraud Warnings" applicable to the state in which I reside.

<u>New York Residents</u>: 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 (Required) *Date*

MEDICAL INFORMATION AND AUTHORIZATION

MEDICAL INFORMATION:

Please provide the names and addresses of all physicians and hospitals who treated the insured within the last five (5) years. If necessary, use a separate sheet of paper.

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

AUTHORIZATION FOR RELEASE OF INFORMATION

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. 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's Signature (Required) *Date*

WAIVER OF PREMIUM BENEFIT CLAIM FORM
Attending Physician Statement

FORM 2W

INSURED INFORMATION

Insured Name _____ Employer Name _____

Insured Date of Birth _____ Social Security Number _____

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?

_____
Month *Day* *Year*

Date patient ceased work because of disability?

_____
Month *Day* *Year*

Has patient ever had the same or similar conditions? ☐ Yes ☐ No If yes, explain:

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Name and addresses of other treating physicians: _____

Did another practitioner refer the Patient to you? ☐ Yes ☐ No If yes, provide name and addresses:

Diagnosis

Current Medical Condition(s)

Primary Diagnosis _____ ICD9 CM Code _____

Secondary Diagnosis _____ ICD9 CM Code _____

Objective finding (including X-Ray, EKG's, Laboratory Data and any clinical finding) _____

Dates of Treatment

Date of First Visit _____ Date of Last Visit _____
Month *Day* *Year* *Month* *Day* *Year*

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other Specify _____

☐ Released from Care Date Released _____
Month *Day* *Year*

Nature of Treatment (Including surgery and medications prescribed, if any)

Progress

Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Has patient been hospital confined? ☐ Yes ☐ No If Yes, Confined Dates

Name and Address of Hospital _____

Cardiac

Functional capacity ☐ Class 1 (No Limitations) ☐ Class 2 (Slight Limitations) ☐ Class 3 (Marked Limitations) ☐ Class 4 (Complete Limitations)

American Heart Association Blood Pressure (last Visit)

_____
Systolic *Diastolic*

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 engage 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 ☐ No

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

Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

Is patient disabled from all other jobs? ☐ Yes ☐ No

Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

If yes, explain _____

If yes, when will patient recover sufficiently to perform duties of his/her job? _____

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

Dates of Total Disability From _____ Through _____

Dates of Partial Disability From _____ Through _____

REHABILITATION

Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary, speech, etc.) ☐ Yes ☐ 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