



*The Company You Keep*®

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

Dear Beneficiary:

Please accept our condolences on your recent loss. 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 review the form in its entirety and then complete it by following the step by step instructions.

If you are also the beneficiary of any other insurance policies with New York Life Insurance Company or its affiliates that insure the deceased, you should contact those offices directly to file a claim.

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

Sincerely,

A handwritten signature in cursive script that reads "Cynthia Elias".

Cynthia Elias  
Vice President



*The Company You Keep*®

## CLAIM FORM FOR GROUP LIFE INSURANCE PROCEEDS

## HOW WE PAY YOUR CLAIM

New York Life 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.

As an additional benefit, beneficiaries receiving insurance proceeds of \$5,000 or more can be paid through a Continued Interest Account. This draft account gives immediate access to all or any part of your proceeds, by simply writing a check. You may write as many checks as you wish, from \$250 up to the full amount in your account. There is no charge to you for the account or the checks. However, if the beneficiary is a corporation, trust, or estate, a single check will be issued.

### Your Account Is Guaranteed

Your Account balance is fully guaranteed by New York Life the company that issued the policy from which benefits are paid. New York Life has consistently received among the highest ratings for our stability and claims paying ability from A.M. Best, Standard & Poor's, and Moody's Investors Service, which monitor the financial services industry.

### Competitive Interest Rates

New York Life guarantees that the interest rates on your Continued Interest Account will be equal to, or greater than, the Bank Rate Monitor average of rates paid on money market accounts by 100 of the largest banks and thrifts nationwide. The rate you earn will be updated weekly and interest is compounded daily. Your proceeds will always be secure, earning interest and easily available to you. For the current interest rate, call our toll free number 1-866-893-6928.

### Immediate Access

As soon as your claim is approved, you will receive a free supply of personalized checks and your account Certificate. This will show the opening balance, current interest rate and all account details. Funds are immediately available to you, simply by writing a check. You may write as many checks as you want each month. There are no monthly fees or maintenance charges. Each month, you will receive a statement showing your account balance, all checks cashed, interest earned, and the current effective annual yield.



### Time to Decide

We know you are facing many important decisions now. Many people need time to carefully consider investment alternatives, that's why we created the Continued Interest Account.

The Continued Interest Account provides many benefits. You can name your own beneficiaries and if you wish, authorize a family member to assist you with your account. In many states, life insurance proceeds are protected from the possible claims of creditors.

In some cases, the insured or owner specified a method of settling a claim. If this has been done, we are obligated to carry out these instructions and we will give you full details. We will also give you additional time to take advantage of any settlement options that may be contained in the original policy.

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.

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. It retains the right to make such determination.

# HOW TO COMPLETE YOUR CLAIM FORM

Please read this page 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.

## **Illinois Interest Statement**

If the certificate was issued in Illinois, you will be paid 9% interest, from the date of death, if your claim is not paid within 15 days of receiving the necessary proof needed to settle the claim.

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## **SECTION 1 – 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 (in Section 6 on the reverse side of the Claim Form) to avoid delay.

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## **SECTION 2 – 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.

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## **SECTION 3 – Beneficiary Information**

Information about the Beneficiary is necessary for claims processing.

**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 and on all proceeds in your Continued Interest Account.

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 "back-up withholdings" because in the past they did not report all their interest or dividends.

If you have been so notified, and a back-up withholding order has not been rescinded, you must cross out the 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 back-up 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.

**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 guardianship papers. If no legal guardian has been appointed, please contact us for further information.

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## **SECTION 4 – Settlement Option**

We offer two payment options: a Continued Interest Account and a Lump Sum payment. If no option is chosen, New York Life will pay the claim into a Continued Interest Account, unless the beneficiary is a resident of Maryland, Michigan, North Dakota, or Washington.

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## **SECTION 5 – Your Signature**

Please sign the Claim Form in the same manner as you would normally sign your checks. Your signature will be used to verify instruction you give us in the future.

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## **SECTION 6 – Medical Information**

Do not fill out the Medical Information and Authorization section unless all or any portion of the insurance coverage is less than two years old at the time of death, or you are making a claim for an accidental death.

# Fraud Statements

## Arizona Fraud Warning

For your protection Arizona law requires the following 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 Fraud Warning

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 Fraud Warning

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 Fraud Warning

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 Fraud Warning

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 Fraud Warning

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and may be subject to fines and confinement in prison.

## New Jersey Fraud Warning

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

## Oregon Fraud Warning

Willfully falsifying material facts on an application or claim may subject you to criminal penalties.

## Pennsylvania 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 subjects such person to criminal and civil penalties.

## Puerto Rico Fraud Warning

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. If aggravating circumstances are 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 Fraud Warning

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.

## Fraud Warning 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.



# 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.

## 1. List all Group Certificates for your claim

Is this claim being made for an Accidental Death Benefit?  YES  NO

If all or any portion of the insurance coverage began within two years of the death of the insured, or if the program contains an Accidental Death benefit, and death was as a result of an accident, please complete and sign the Medical Information and Authorization in Section 6. In the case of an accidental death, also send us copies of police or coroner's report and any news articles.

Are the Group Certificates attached?  YES  NO If no, please explain  Lost  Other \_\_\_\_\_

## 2. Deceased Information

Name \_\_\_\_\_ Date of Death \_\_\_\_\_  
*First Middle Initial Last Month Day Year*

List all other names by which the deceased was known: \_\_\_\_\_

Cause of Death:  Natural  Suicide  Accident  Homicide  Unknown  Other

## 3. Beneficiary Information

Name: \_\_\_\_\_ Sex:  Male  Female  
*First Middle Initial Last*

Address: \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
*Street Apartment Number*

\_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
*City State Zip Code*

Claimant's Social Security or Taxpayer Identification Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
*Month Day Year*

I have **not** been notified by the Internal Revenue Service that I am subject to back-up withholding as a result of failure to report all interest or dividends, or I am exempt. **Cross out this statement if you have been so notified.**

In what capacity are you making this claim?  Beneficiary  Executor  Trustee  Assignee  Other: \_\_\_\_\_

Claimant's Relationship to the Deceased:  Spouse  Child  Parent  Grandchild  Other: \_\_\_\_\_

## 4. Settlement Options

You are automatically eligible for the Continued Interest Account if you are a named beneficiary and your proceeds are \$5,000 or more and the member has not pre-selected an alternate option. If you are a resident of Maryland, Michigan, North Dakota, or Washington, and no payment option is chosen, payment will be made in a lump sum. \*\*Please note that CIA payments must be made to your physical address and cannot be made to P.O. Boxes. If you would like another settlement option, please indicate that choice here: \_\_\_\_\_

## 5. Your Signature

I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status information in Section 3 are correct. I further certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete form W8-BEN). I understand that my signature will be used for signature verification for my Continued Interest Account.

**In addition, I have read and understand the Fraud Statement that is 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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**6. Medical Information and Authorization**

Complete this section ONLY IF all or any portion of life insurance coverage was issued within two years of the death of the insured, or if you are making a claim for an Accidental Death Benefit.

**MEDICAL INFORMATION:**

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

Physician/Doctor 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 including its agents, parent or subsidiary companies and attorneys, reinsures, insurance support groups and independent administrators who are acting on their behalf. Information released may include records of medical advise, medical care, medical treatment of AIDS or AIDS -related diseases, mental illness, drug or alcohol use, other insurance coverage, financial and employment history. This information may be released by medical professionals or facilities, pharmacies, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators. When requesting information from any of the sources named above, a copy of this form is as good 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.

*Signature* \_\_\_\_\_ *Relationship to Insured* \_\_\_\_\_ *Date* \_\_\_\_\_



**ADDITIONAL INFORMATION REGARDING THE CONTINUED INTEREST ACCOUNT**

For proceeds placed in a Continued Interest Account, the funds will remain with the New York Life insurance company that issued the insurance policy. Account services will be provided by the Northern Trust Company. The funds will be guaranteed by the financial strength of the insurer for as long as the proceeds remain in the Continued Interest Account; however, they are not FDIC insured.

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