CRITICAL ILLNESS CLAIM FORM

Original documents will not be returned

AVMA LIFE®
Veterinarian Inspired Coverage

MEMBER'S STATEMENT

Member's Name: _____ Group No: _____ Cert No.:_____
First *Middle* *Last*

Address: _____
Street City State Zip Code

Telephone Number: (____)_____ Date of Birth: _____/___/_____ ☐ Male ☐ Female
Month Day Year

Email: _____

Social Security Number: _____

Present Occupation: _____

Describe fully the extent and nature of your critical illness for which the claim is being made? _____

_____

On what date did you first consult a medical practitioner in connection with your critial illness?

Date: _____

Name: _____

Address: _____

Telephone Number: (_____)_____

When was the critcal illness first diagnosed? _____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "yes" give full details below.

_____

MEMBER'S SIGNATURE

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.

Member's Signature: _____
(The member or someone on his/her behalf must sign here and on the Authorization for Release of Information form that is on page 4.)

Date: _____/_____/_____
Month Day Year

Please return completed form to:
AVMA LIFE TRUST PROGRAM
ADMINISTRATOR
1200 E. Glen Ave
Peoria Heights, IL 61616
(800)-321-6360

CRITICAL ILLNESS CLAIM FORM

Attending Physician Statement

AVMA LIFE
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Member's Name: _____ Member's Date of Birth: _____/_____/_____
Month Day Year

When did signs and/or symptoms first appear? _____

Diagnosis (including complications): _____ ICD-10 CM CODE: _____

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

CANCER/CARCINOMA IN SITU

Date of diagnosis (the date the pathological specimen(s) were obtained on which cancer was diagnosed): _____

Was the cancer ☐ Pathologically Diagnosed, or ☐ Clinically Diagnosed Stage: _____ Grade: _____

If the cancer or carcinoma in situ was pathologically diagnosed, attach a copy of the pathology report. If the cancer was clinically diagnosed, please provide the reason(s) that pathological diagnosis was not obtained and attach medical evidence that supports the diagnosis of cancer.

MYOCARDIAL INFARCTION (HEART ATTACK)

Does the member's condition meet all of the following criteria:

1. Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction?
   Attach a copy of the EKG's and reports. ☐ Yes ☐ No
2. Were cardiac enzymes elevated above standard laboratory levels of normal?
   Attach a copy of the lab report. ☐ Yes ☐ No
3. Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries?
   Attach copies of any applicable reports. ☐ Yes ☐ No
4. Did the member have chest pain consistent with myocardial infarction? ☐ Yes ☐ No

Date of diagnosis (the date the member met all of the above criteria for myocardial infarction): _____

MAJOR ORGAN TRANSPLANT

Did the member undergo surgery to receive a human heart, liver, lung, kidney, small intestine, bone marrow or pancreas?
If so, attach a copy of the operative report. ☐ Yes ☐ No

What condition caused the need for the major organ transplant? _____

When was the member first treated for signs or symptoms of this condition? _____

Is patient registered by the United Network of Organ Sharing (UNOS)? _____

STROKE

Did the member have a stroke, which produced: neurological sequela that lasted more that 96 hours; and is expect to be permanent?
Stroke does not include a Transient Ischemic Attack and attack of Verterbrobasilar Ischemia. ☐ Yes ☐ No

Date of diagnosis (the date of stroke occurred): _____

RENAL FAILURE

Does the member have end stage renal disease due to chronic irreversible failure of both kidneys to function, which requires regular peritoneal dialysis, hemodialysis or renal transplantation? ☐ Yes ☐ No

What caused the member's renal disease? _____

When was the member's first treated for signs or sysmptoms of renal disease? _____

Date of Diagnosis? _____

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) may be required.

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.

_____
Attending Physician Name (Please Print) Specialty Telephone Number

_____
Address City State Zip Code

_____
Physician Signature Date

AVMA LIFE
Veterinarian Inspired Coverage

AVMA LIFE Trust Program
Administrator
1200 E. Glen Ave
Peoria Heights, IL 61616

Authorization for Release of Information

TO: All providers of medical services and supplies, pharmacy related service organizations, prescription history database suppliers, employers, insurance institutions, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company or their representative, any independent claim administrators, consulting health professionals, pharmacy related service organizations and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV) and prescription records. This information will be used to evaluate claims for benefits.

In Oklahoma, the information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying New York Life in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

_____ _____
Patient's Signature Date

_____ _____-_____-_____
Print Name Social Security No