AVMA LIFE®
Veterinarian Inspired Coverage

DISABILITY INCOME/PROFESSIONAL OVERHEAD EXPENSE CLAIM INSTRUCTIONS

(PLEASE KEEP THIS NOTICE FOR FUTURE REFERENCE)

NEED HELP FILING YOUR CLAIM?

Please view our easy-to-use claim guide(s) provided with this form and available online at AVMALIFE.org on the respective product page. The Claim Guide provides step-by-step instructions to filing a claim for disability benefits. Please be sure to:

- Answer all questions on the **Member's Statement of your Disability Income/Professional Overhead Claim** form on page 1, 2, and 3 and sign and date the bottom of Page 3 where indicated.
- Sign and date the **Authorization for Release of Information** on Page 4, and
- Have your Medical Provider complete the **Medical Provider's Statement** on pages 5 and 6.
- Read the applicable Fraud Notice for your resident jurisdiction on pages 7 & 8
- Complete the *optional* **Electronic Fund Transfer (EFT) form** for benefit payments, if approved, to be deposited directly into your bank account. If you do not include this form, New York Life will mail the benefit payment, if approved, to your residential address provided on this form.

Please return the completed claim form to:
AVMA LIFE Trust Program Administrator
Pearl Insurance
1200 E. Glen Ave
Peoria Heights, IL 61616

If you have any questions concerning your request for benefits, you may call (800) 621-6360.

IMPORTANT NOTICE - YOUR CLAIM MAY BE CONTESTABLE:

If a claim is submitted within two years from the effective date of medically underwritten coverage, New York Life will conduct a routine investigation to determine whether any adverse medical or financial history may have altered New York Life's decision to approve the coverage. This investigation will be completed, regardless of cause, and will require the insured to provide a complete medical history for the five-year period prior to the effective date of the new or increased coverage.

IF YOU RECOVER OR RETURN TO WORK:

After you file a disability claim, if you recover or return to work, please notify New York Life immediately by completing and mailing the **Statement of Recovery or Return-to-Work** form on the next page and return it to:

New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

If you have any questions concerning your claim, you may call New York Life Insurance Company's Disability Claims Unit at (800) 695-4226, Menu 1.

STATEMENT OF RECOVERY OR RETURN TO WORK

Return the completed form to:

New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

Name: _____ Social Security Number: _____

Address: _____

_____

Policy No.: 14884-0 Claim No.: _____ Certificate Number:_____

I recovered: ☐ Date:_____ I returned to work: ☐ Date: _____
MM/DD/YYYY MM/DD/YYYY

Other:

Date: _____ Signature:_____
MM/DD/YYYY

Telephone No.:_____ Print Name: _____

DISABILITY INCOME/OFFICE OVERHEAD EXPENSE CLAIM FORM

Association: AVMA G-14884 Member's Social Security # _____-_____-_____

Certificate No:_____ Male ☐ Female ☐ Height: _____ Weight: _____ Date of Birth: _____

Member's Name:_____ Email:_____

Residential Address:_____
(No.) (Street) (Apt.)

_____
(City or Town) (State) (Zip Code)

Tel. # Home: _____ Cell: _____ Work: _____

Employer's Name: _____

_____
(No.) (Street) (Suite #)

_____
(City or Town) (State) (Zip Code)

Specialty:_____ Self Employed? Yes ☐ No ☐

Date Last Worked: _____ Normal Number of Hours Worked per week: _____

Percentage of Premium Paid by Member:_____%*

Percentage of Premium Paid by Firm/Employer_____%**

Average Monthly Earned ***Income During the 12 Months Prior to Disability Gross: $_____Net: $_____

*If you are an employee, is your employer paying all or portion of the premium? If so, indicate the percentage they are paying on the second line and the percentage you are on the first.

**If you own all or a portion of your practice, is all or a portion paid by or reimbursed to you by the practice? If so, indicate the percentage your practice is paying/reimbursing you on the second line and the percentage you are paying from personal funds or not being reimbursed for on the first.

***Income from wages, salaries, fees, any other amounts received for personal services, commissions, bonuses, fringe benefits, share of monthly net profit of a corporation and share of stock ownership reportable to the IRS. Please review the definition of AVERAGE NET MONTHLY INCOME in your Certificate of Insurance.

Collateral Assignment

Did you file a collateral assignment for Disability Income or Professional Overhead Expense Benefit? No ☐ Yes ☐ (attach copy)

Assignee Name:_____

Assignee Address:_____

Monthly Amount Assigned:_____ Tax I.D. Number:_____

What is the nature of your disability**?** _____

Is disability due to an accident (Including automobile accident)? Yes ☐ No ☐ If "Yes", when?_____

Where? _____ How? _____

Date first treated for this disability: _____ Date first unable to work: _____

Have you attempted to return to your occupation or other employment since the date disability began? (If so, give details):

If returned to work or recovered, give date: _____ Returned to work: Full-Time: ☐ Part-Time ☐

If part-time, number of hours per day? _____ Days per week: _____

If you have not yet returned to work, when do you expect to? _____

Type of Practice/Occupation: _____

Please fully describe the duties of your practice/occupation at the time you stopped working, including the percentage of time at each activity.

What are your daily activities at this time?

NAMES AND ADDRESSES OF FIRST PROVIDER CONSULTED AND OTHER PROVIDERS INCLUDING YOUR PRESENT ATTENDING PROVIDER.

Name: _____ Telephone No.: _____

Address: _____

Treated From: _____ To: _____

Name: _____ Telephone No.: _____

Address: _____

Treated From: _____ To: _____

Name: _____ Telephone No.: _____

Address: _____

Treated From: _____ To: _____

Name: _____ Telephone No.: _____

Address: _____

Treated From: _____ To: _____

Are you receiving or will you be entitled to receive benefits from any of the following:

Social Security Law? Yes ☐ No ☐ Retirement or Pension Plan? Yes ☐ No ☐

Salary or other compensation? Yes ☐ No ☐ Another Group Insurance Plan? Yes ☐ No ☐

Individual Disability Income Policy? Yes ☐ No ☐

For those applying for Professional Overhead Expense Benefits: Another Overhead Expense Policy? Yes ☐ No ☐

If any of the above was answered "Yes", please complete the information requested below:

Policy No.	Claim No.	Name and Address of Payer	Amount of Payment

I declare that the answers on Pages 1, 2 and 3 of this form are complete and true to the best of my knowledge. Furthermore, **I agree that I will advise New York Life Insurance Company of my return to any type of work, and I will return payments to which I am not entitled to by reason of my return to work or termination of my Covered Disability**.

ANY PERSON WHO KNOWINGLY PRESENTS A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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**.**

Date: _____ Member's Signature:_____

The Member or someone on his/her behalf must Sign here and the *Authorization for Release of Information* form on page 4.

NOTE 1: New York Life will use the email address you provide on Page 1 to acknowledge receipt of this claim.

NOTE 2: We offer direct deposit of your benefits, should they be approved, through Electronic Fund Transfer (EFT) to your bank account. If desired, complete, and return Page 9 now, or hold onto it for a future date

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.

MEDICAL PROVIDER'S STATEMENT

(The patient is responsible for the completion of this form without expense to the Company)

Notice to Provider: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME:_____ DATE OF BIRTH: _____
   First Middle Last

2. CURRENT MEDICAL CONDITION(s): GROUP POLICY#: G-14884

   PRIMARY DIAGNOSIS: _____ ICD-10 CM CODE _____

   SECONDARY DIAGNOSIS: _____ ICD-10 CM CODE _____

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: _____
   MM/DD/YYYY

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION? _____
   MM/DD/YYYY

   DATE THAT PATIENT LAST CONSULTED YOU FOR THIS CONDITION? _____
   MM/DD/YYYY

5. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTICIONER: Yes ☐ No ☐
   (If "Yes", please provide the name and address of that practitioner):

6. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR IMNJURY OR SICKNESS? Yes ☐ No ☐
   (If "Yes", please provide details and date(s) of prior treatment):

7. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? Yes ☐ No ☐
   (If "Yes", please provide diagnosis(es) and date(s) of prior treatment):

8. OBJECTIVE FINDINGS
   (Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDD)*:*

9. HAS PATIENT BEEN HOSPITALIZED? Yes ☐ No ☐ ***(If "Yes", provide reason, hospital name, and dates of confinement)****:*

10. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED?
   (**Include surgery and medications prescribed, if applicable**):

(5) **Continued on next page**

MEDICAL PROVIDER'S STATEMENT
(Continued From Previous Page)

11. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? Yes ☐ No ☐

12. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? Yes ☐ No ☐
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK?

PATIENT WILL BE ABLE TO PERFORM SOME WORK? _____ MM/DD/YYYY

13. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES NO ***(If "Yes", please describe):***

14. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

a) THE PATIENT WAS UNABLE TO WORK FROM: _____ MM/DD/YYYY THROUGH: _____ MM/DD/YYYY

b) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: _____ MM/DD/YYYY THROUGH: _____ MM/DD/YYYY

15. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO HIS OR HER MEDICAL CONDITION ***(If none, indicate "NONE"):***

16. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? Yes ☐ No ☐

IF "YES" DATE RELEASED FROM YOUR CARE: _____ MM/DD/YYYY

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: _____ MM/DD/YYYY

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 copies of medical records when requested) will be required in the event of a continuing claim.

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.

PROVIDER'S NAME (PLEASE PRINT) _____ SPECIALTY _____ TELEPHONE NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PROVIDER'S SIGNATURE _____ DATE SIGNED (MM/DD/YYYY) _____

Please return completed form to:
AVMA LIFE Trust Program Administrator
1200 E. Glen Ave
Peoria Heights, IL 61616

STATE FRAUD NOTICE

FOR ALABAMA RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof."

FOR ALASKA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR 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 the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the 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."

FOR 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."

FOR 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 claimant for the purpose of defrauding or attempting to defraud the 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."

FOR DELWARE RESIDENTS
"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR 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."

FOR FLORIDA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS
"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS
"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR INDIANA RESIDENTS
"A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony."

FOR 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."

FOR 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."

FOR MAINE 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 or denial of insurance benefits."

FOR MARYLAND RESIDENTS
"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 confinement in prison."

FOR MINNESOTA RESIDENTS
"Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

FOR NEW HAMPSHIRE RESIDENTS
"Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

FOR 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 in New Jersey."

FOR NEW MEXICO 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 civil crimes and criminal penalties."

FOR OHIO RESIDENTS
"Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of Insurance Fraud."

FOR OKLAHOMA RESIDENTS
WARNING: "Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony."

FOR OREGON RESIDENTS
"Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals, for purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud."

FOR 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."

FOR PUERTO RICO RESIDENTS
"Any person who, knowingly, and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with the fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

FOR 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.

FOR 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."

FOR VERMONT 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."

FOR VIRGINIA 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 or denial of insurance benefits."

REQUEST FOR ELECTRONIC FUND TRANSFER (EFT)

Name: _____

Street Address: _____

City, State Zip Code _____

Policy No.: G14884-0 _____

If available, please provide: Claim No.: _____ Certificate Number:_____

Dear Disability Claimant:

New York Life Insurance Company offers direct deposit of your benefits, should they be approved, through Electronic Fund Transfer (EFT) to your bank account.

With the EFT option, you will receive an Explanation of Benefits mailed to your home address. The claim funds go directly into the account you select.

To take advantage of the EFT option, you need to provide us the account number of the bank account and your bank's routing number. This is generally on your check so a voided check from your checking account or a deposit slip for your savings account with the bank routing information can be provided. The payment will set up to be sent to your account approximately 8 days before the end of the month. This will eliminate the worry about receipt of your disability checks through the US mail and save you a trip to the bank. You will need to keep us advised in any change to your account because if the account is closed, the EFT will be rejected.

We believe this streamlining of payments will provide a feeling of security to you and eliminate unnecessary steps. If you wish to elect this option, please sign the bottom of this letter, and return the letter and a copy of your check or savings account deposit slip with your claim form. Please also provide a telephone number, where indicated below, so we can contact you with any questions.

If you don't want to elect EFT at this time, you can make the request any time in the future by mailing the form to:

New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

I am requesting payment be made by EFT.

Attached is:

☐ A voided check for a Checking Account.

☐ A deposit slip for a Saving Account.

_____ _____
Print Name Date

_____ _____
Signature Telephone No.