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 situation. 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 and Medical Information and Authorization in its entirety and have your doctor complete the Attending Physician Statement.

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

Sincerely,

Kathleen Scollan
Vice President and CFO

CLAIM FORM FOR DISMEMBERMENT BENEFITS

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

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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.

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.

ACCIDENTAL DISMEMBERMENT CLAIM FORM *Please type or print clearly.*
Please return this Claim Form and any other documentation required to the address the Plan Administrator has provided to you. No original documents will be returned.

INSURED STATEMENT

INSURED INFORMATION

Insured Name _____ Group Number _____

Address _____ Social Security No. _____

Telephone Number ( ) _____ Date of Birth _____
Month Day Year

ACCIDENT INFORMATION

Date and time of Accident _____ Place of Accident _____

Occupation at time of Accident _____

Date last worked full time _____ Date of dismemberment _____

Describe fully how the accident occurred, the nature of injuries received, and loss(es) for which claim is made.

_____

_____

_____

Did the loss arise out of or in the course of your employment? ☐ Yes ☐ No

Do you have any other life or accident insurance? ☐ Yes ☐ No

If yes, with what companies? _____

YOUR 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.

Under penalties of perjury, I certify: (1) my social security number or Tax ID number shown on this application is my correct taxpayer identification number, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding, (3) I am a U.S. person (includes a U.S. resident alien), and (4) I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

☐ Check this box if the IRS has notified you that you are subject to backup withholding.

If I am not a U.S. citizen, U.S. resident alien or other U.S. person, I am submitting the applicable Form W8 with this form to certify my foreign status and, if applicable, claim treaty benefits.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____

Signature (Required) *Date*

MEDICAL INFORMATION AND AUTHORIZATION:

Please provide the names, addresses, and telephone numbers of all physicians, hospitals, or other medical facilities that treated and are currently treating the insured for the accident resulting in the loss. 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, affiliates 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 evaluate 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 that 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 agencies. In this case, the information may no longer be protected by the rules governing this authorization.

Insured's Signature: _____ Date: _____

ACCIDENTAL DISMEMBERMENT CLAIM FORM *Please type or print clearly.*

Attending Physicians Statement

MEDICAL INFORMATION

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.

Name of Patient _____ Social Security No. _____

Nature of Loss _____ Date of Loss _____

How did the loss occur? _____

_____

_____

In your opinion, was the loss due to an accident? ☐ Yes ☐ No

Date of Accident _____

If loss of sight is involved, in your opinion, is the loss of sight irrecoverable? ☐ Yes ☐ No

If yes, please give date on which such loss became irrecoverable _____
Month Day Year

Vision prior to accident Right Eye _____ Left Eye _____

Vision after accident Right Eye _____ Left Eye _____

If injury or disease required surgical operation (manual or instrumental) give description of operation and date performed. _____

_____

In your opinion, was any disease an underlying cause in this loss? ☐ Yes ☐ No If yes, explain

_____

Was the patient confined to a hospital as a result of the loss? ☐ Yes ☐ No If Yes, please name facility:

_____
Hospital or Facility Name *Telephone*

_____
Address *City* *State* *Zip Code*

_____

_____ ( )
Attending Physician Name: (Please Print) Degree Telephone Number

_____
Address City State Zip Code

Physician Signature _____ Date _____

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