Application for Life Insurance Benefits

NEW YORK LIFE

State Variations of Fraud Warnings

Kindly refer to the state specific insurance department fraud information below

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 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.

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.

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.

Kentucky 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.

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 Hampshire 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.

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

New York 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.

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.

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.

New York Life Insurance Company
ATTN: Claims Department
PO Box 31683
Tampa, FL 33631-3683

How to File a Claim for Life Insurance Benefits

Submitting a Claim

To review a claim for life insurance benefits, the following documents must be completed and returned:

- A fully completed claim form from each beneficiary
  - For additional claim forms, please visit our website at **nylexpress.com**
- One death certificate
  - Please note, no original documents will be returned
- If the benefits are being assigned to a funeral home, a copy of the itemized funeral bill along with a Funeral Home Assignment form
- Additional information can be found under Frequently Asked Questions
- We reserve the right to request additional documents in order to complete our claim review

What To Expect After You Submit Your Claim

We are dedicated to processing your claim promptly. After receiving all required claim documents, a Claims Examiner will contact you if any additional information is needed.

Questions

If you have any questions or if you need any assistance in completing the required claim forms, please call us toll free at (800) 887-1255 Monday through Friday between the hours of 8:00 AM and 5:00 PM (Eastern Time).

Document Submission

Please ensure your name and policy number are on all documents.

Please send all life insurance claim requirements to:
New York Life Insurance Company
ATTN: Claims Department
PO Box 31683
Tampa, FL 33631-3683

For overnight mail, please use the following address:
New York Life Insurance
ATTN: Claims Department
8641 Henderson Road, Tampa FL 33634

Illinois Interest Statement: Notice pursuant to Illinois Insurance Code 215 ILCS 5/224: For certain life insurance policies issued in Illinois, any payment made more than 31 days after the latest of the following to occur will be credited with 10% interest from the date of death through the date of payment: (1) the date we receive your due proof of loss; (2) the date we receive information sufficient to determine our liability and the appropriate payee of the proceeds; (3) the date we receive notice that legal impediments to the payment of proceeds are resolved.

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Frequently Asked Questions:

How do I obtain a death certificate?

Most funeral homes will provide the family of the deceased with several death certificates. You may also contact the Vital Records Division in the state of the deceased for this document. If the manner of death is pending on the death certificate we receive, we may require an additional death certificate listing the final manner of death.

Required items for special beneficiary scenarios *(Note: Additional documents may be requested)*

- **Deceased Beneficiary -** Please provide a copy of the death certificate for the deceased beneficiary.
- **Minor Beneficiary -** Please complete Section 3 of the Claim Form with the minor's information including Name, Social Security Number and Date of Birth. Submit a copy of the court document appointing the guardian of the minor child's property/estate. If a legal guardian has not been established for the property/estate of the minor child, payment may be considered under the Uniform Transfers to Minors Act (UTMA) or the Uniform Gifts to Minors Act (UGMA) subject to state guidelines. Note: The guardian of the minor's "person" is not necessarily the custodian of the minor's property/estate.

What is a funeral home assignment (FHA)?

A FHA is a binding agreement between a beneficiary and the funeral home. This will allow us to direct a payment to the funeral home. The FHA must be signed by the beneficiary and must be received in our office prior to the settlement of the claim. We are obligated to honor the assignment and pay the funeral home accordingly.

What is an incontestable claim?

A claim is considered incontestable when the insured's death occurs two or more years **after** the insurance date, reinstatement date, or the effective date of any rider.

What is a contestable claim?

A claim is contestable when the insured's death occurs **within** two years of the insurance date, reinstatement date, or effective date of any rider. For contestable claims, sections 5 & 6 of the claim form must also be completed.

Are life insurance proceeds subject to taxation?

Any interest paid on death proceeds is subject to federal and state taxation. We will not withhold income tax from interest unless you have advised us that you are subject to backup withholding or if the taxable portion of all payments for the year is greater than $10.00. Interest is paid on most claims from the date of death until the date the claim is paid. The Social Security Number or Tax Identification Number is required to report interest payments to the Internal Revenue Service.

What is IRS Tax Form 1099-INT?

Form 1099-INT is utilized to report to the Internal Revenue Service interest payments made to an individual or entity (such as a Trust or Estate) during any calendar year. Form 1099-INT is mailed to an individual or entity in January of the year following the interest payment(s). Form 1099-INT provides the individual or entity of the interest amount to be reported on their tax return.

What is the Foreign Account Tax Compliance Act (FATCA)?

FATCA is a United States law designed to combat tax evasion by U.S. persons/entities. Provisions to the law include expansive withholding and information reporting rules aimed at ensuring U.S. persons and entities with financial assets outside the U.S. are paying U.S. taxes.

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Please print clearly

To be completed by each Beneficiary. To enable us to expedite the consideration of this claim, please fully and completely answer each question, sign and date all forms.

Section 1 – List All Policies For Which You Are Submitting a Claim

Policy Number(s)

Section 2 – Insured's General Information

Name of Deceased (FIRST / M.I. / LAST) | Nickname or Maiden Name

Birthdate (MONTH / DAY / YEAR) | Date of Death (MONTH / DAY / YEAR)

Manner of Death: ☐ Natural ☐ Accident* ☐ Unknown ☐ Suicide* ☐ Homicide* ☐ Other | Cause of Death

*Please attach copies of police and coroner's report and any relevant news articles.

Section 3 – Beneficiary Information — If Beneficiary is an Estate or Trust, please list the name of the Estate or Trust

Beneficiary Name (FIRST / M.I. / LAST) | Birthdate (MONTH / DAY / YEAR)

Mailing Address of Beneficiary (STREET / SUITE. / CITY / STATE / ZIP)

Relationship to the Deceased: ☐ Spouse ☐ Child ☐ Grandchild ☐ Parent ☐ Other *(relationship)*

Mobile Number

Alternate Number | E-Mail of Beneficiary

Income Tax Certification:

Enter your **Social Security Number** if you are an individual beneficiary.

Enter **Taxpayer Identification Number** if claiming benefits as an Estate, Trust or Corporation.

Check **only** if statement below applies:

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends.

Capacity under which you are making this claim (check one):

☐ **Individual Beneficiary –** If you are requesting benefits to be paid to the funeral home, a copy of the assignment is required.

☐ **Estate Executor –** Be sure to submit a copy of the certified appointment papers and provide Estate Tax ID. Claim Form must be signed by all Estate Representatives.

☐ **Trustee –** A copy of the Title, Signature and Notary pages of the Trust are required, including the pages showing the Trustee and Successor Trustee. Provide Trust Tax ID. Claim Form must be signed by all Trustees.

☐ **Collateral Assignee –** A copy of the assignee's statement of interest must be provided. Claim form must be signed by the assignee or their authorized representative.

☐ **Corporate Officer –** Claim Form must be signed by Corporate Officer(s) and must indicate the title by which you are authorized to act on behalf of the company.

☐ **Guardian/Custodian of the Minor Beneficiary –** If a legal guardian of the child's estate/property has been appointed by the court, he or she must sign on behalf of the minor child and submit a copy of the guardianship papers. If signing under the UTMA/UGMA, please sign your name and indicate your relationship (father, mother, etc) to the minor child as "Custodian of (name of child), under the (name of resident state), UTMA/UGMA".

Section 4 – Beneficiary's Signature

Please refer to the enclosed page entitled STATE VARIATIONS OF FRAUD WARNINGS for specific notices in certain jurisdictions. **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.

I have read and understand the Fraud Statement that is applicable in the state in which I reside.

Under penalties of perjury, I (as beneficiary named) 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) the FATCA code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. (Please note: if being submitted for a U.S. account, this last certification (4) does not apply).

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

If I am a U.S. entity, I am submitting a completed IRS Form W-9. If Signature am not a U.S. Citizen, U.S. resident alien or other U.S. person, I am submitting the applicable IRS Form W-8 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.

X

Signature (REQUIRED) | Print Name | Date

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Section 5 – HIPAA Authorization

HIPAA-Compliant Authorization

Complete if :

(a) the death occurred within two years of the issue date, rider effective date, or reinstatement date,
(b) the death was due to an accident and the policy contains the Accidental Death Benefit, or
(c) specifically requested.

I give my permission to release information concerning

Name of Insured FIRST	M.I.	LAST
Policy Number(s)		Insured Birthdate MONTH / DAY / YEAR
Date of Death MONTH / DAY / YEAR		Insured's Social Security ___ — ___ — ___

to New York Life Insurance Company including its agents, affiliates or subsidiary companies and attorneys, reinsurers, 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 but excludes psychotherapy notes. This information may be released by medical professionals or facilities, pharmacies, pharmacy benefit managers, 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.

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 understand that I must sign this authorization in order for my claim to be processed.

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.

X _____
Signature | Print Name | Date

_____
Relationship to Insured*

*Authorized Representative must provide proper documentation, such as Estate representation documents.

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Section 6 – Medical Information

This section should ONLY be completed if (a) the death occurred within two years of the issue date, rider effective date, or reinstatement date, or (b) the death was due to an accident and the policy contains the Accidental Death Benefit, or (c) specifically requested. Please complete this section in its entirety.

Other Life Insurance for the Insured

Company Name	Policy Number
Company Name	Policy Number

Physicians and Hospitals Who Treated the Insured

Please provide the names and addresses of all physicians and hospitals that may have treated the insured within the last five years.

☐ Check here if a separate sheet is attached with additional providers. This sheet must be signed and dated.

Primary Care Physician:

Address

STREET SUITE. CITY STATE ZIP

Phone Number	Dates Treated	Condition(s)

Physician/Hospital:

Address

STREET SUITE. CITY STATE ZIP

Phone Number	Dates Treated	Condition(s)

Physician/Hospital:

Address

STREET SUITE. CITY STATE ZIP

Phone Number	Dates Treated	Condition(s)

Physician/Hospital:

Address

STREET SUITE. CITY STATE ZIP

Phone Number	Dates Treated	Condition(s)

Physician/Hospital:

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Phone Number	Dates Treated	Condition(s)