AARP® | Life Insurance Program from NEW YORK LIFE

New York Life Insurance Company
AARP Operations
Claims Service
P.O. Box 30713
Tampa, FL 33630-3713
1-800-695-5165

Dear Beneficiary:

Please accept our condolences on your recent loss. We understand this is a difficult time, and hope that we can alleviate any concerns you may have about your claim.

We are providing the enclosed Claim Form complete with step-by-step instructions on how to submit your claim. Please return the completed Claim Form along with a certified death certificate and any additional requested documents, so that we can process your claim as soon as possible.*

We have provided a Frequently Asked Questions section containing information that will assist you in completing the Claim Form.

We appreciate the trust placed in us and are proud to continue that tradition in service to you. If you have any questions, please call 1-800-695-5165. Representatives are available from 8 a.m. to 5 p.m. (Eastern Time) Monday through Friday.

Sincerely,

Roderick L. Boggs
Roderick L. Boggs
Corporate Vice President

*New York Life reserves the right to determine whether any insurance was in force at the time of death, as well as the beneficiary to whom proceeds may be payable.

HOW TO COMPLETE YOUR CLAIM FORM:

To facilitate the processing of your claim, please send us a fully completed Claim Form from each beneficiary, one certified death certificate and other documents that we may request. For additional Claim Forms, visit our website at nylaarp.com

No original documents will be returned.

Section 1: List all the Contracts under which you are making a claim.

Section 2: Information about the deceased is necessary for purpose of identification and benefit determination.

Section 3: Beneficiary information and siganture instructions:

Taxpayer Identification Number: Life insurance benefits are generally not subject to income tax. However, New York Life pays interest on the insurance proceeds from the date of death. Since the interest paid to you may be taxable, you should consult your tax advisor.

The Federal Government requires us, and all other financial institutions, to report interest we pay to you. Therefore, we are required to obtain your Social Security or other Taxpayer Identification Number, which you must certify under penalties of perjury. If you are applying for a tax 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 may have been notified by the Internal Revenue Service that they are subject to "backup withholding" because in the past they did not report all their interest or dividends. If you have been so notified, and a backup withholding order has not been rescinded, you must check the Backup Withholding section right below your Income Tax Certification. We may contact you for more information if there are any questions about your Taxpayer Identification Number or back up withholding status, or if you are a non-resident alien or foreign entity.

Section 4: Please sign the Claim Form in the same manner as you would normally sign your checks. Your signature may be used to verify instructions you give us in the future.

Sections 5 and 6: In order to expedite the processing of your claim, please complete the Authorization and Medical Information sections if all or any portion of the insurance coverage is less than two years old at the time of death.

Illinois Interest Statement:
If the contract was issued in Illinois, you will be paid 10% interest, from the date of death, if your claim is not paid within 31 days of receipt of the necessary proofs needed to settle the claim.

Please send your fully completed Claim Form and one certified death certificate, along with any additional requested documentation to:

Regular Mail

New York Life Insurance / AARP Operations
ATTN: Claims Department
PO Box 30713
Tampa, FL 33630-3713
1-800-695-5165

Express Mail:

New York Life Insurance /AARP Operations
ATTN: Claims Department
5505 W. Cypress Street
Tampa, FL 33607
1-800-695-5165

FREQUENTLY ASKED QUESTIONS:

How do I obtain a certified death certificate, and how do I know the death certificate I receive is certified?

Most funeral homes will provide the family of the deceased with several certified death certificates. You may also contact the Vital Records Division in the state of the deceased for this document. Certified death certificates contain the signature of an appropriate officer of the county, city or state and will have either a raised seal or a multicolored signature seal from the county, city or state of issuance. If the manner of death is pending on the death certificate we receive, we will require an additional death certificate listing the final manner of death.

The designated beneficiary is deceased, what do we do?

Please provide a copy of the certified death certificate for the deceased beneficiary.

What is a funeral home assignment?

A funeral home assignment is a binding contract between a contract owner or beneficiary and the funeral home. This will allow us to direct payment of all, or a portion of the proceeds, to the funeral home. The funeral home assignment 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. In some instances, a collateral assignment may have been made prior to the owner's death.

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. On contestable claims, the HIPAA Compliant Authorization section must be signed.

What if the beneficiary is a minor?

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 custodian 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. Please contact our office for further information. Note: The custodian of the minor's "person" is not necessarily the custodian of the minor's property/estate.

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 less than $200.00. 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?

Forms 1099-INT are 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. Forms 1099-INT are mailed to an individual or entity in January of the year following the interest payments. From 1099-INT informs the individual or entity of the interest amount to be reported on their tax return.

What is FATCA?

The Foreign Account Tax Compliance Act, (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.

What if the insured was confined in a skilled nursing home for 180 consecutive days prior to his/her death?

Additional benefits may be available and their eligibility is outlined in the Contract Provisions.
Contact New York Life for specific information.

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Claim Form

Please type or print legibly

1. List below only the Contracts under which you are making a claim.

Insurance Contract Number(s):

2. Deceased Insured Information.

Name of Deceased: (First, Middle, Last)

Nickname or Maiden Name:

Birthdate: _____ – _____ – _____ (MM – DD – YYYY)

Date of Death: _____ – _____ – _____ (MM – DD – YYYY)

Manner of Death: ❑ Natural ❑ Accident* ❑ Unknown ❑ Suicide* ❑ Homicide* ❑ Other

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

3. Beneficiary Information. If Beneficiary is an Estate or Trust, please list the name of the Estate or Trust

Beneficiary Name: (First, Middle, Last)

Mailing Address of Beneficiary:

Street

City

State

Zip

Relationship to the Deceased: ❑ Spouse ❑ Child ❑ Grandchild ❑ Parent ❑ Other:

Birthdate: _____ – _____ – _____ (MM – DD – YYYY)

Home Phone:

Alternate Phone:

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 the 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 the 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:** 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.

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.

- **I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status in Section 3 are correct. I also certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete form W8-BEN).**
- **I am exempt from the Foreign Account Tax compliance Act (FATCA) reporting.**
- **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) Print Name: Date:

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5. Authorization.

HIPAA-Compliant Authorization

To expedite the processing of your claim, please complete this page in its entirety.

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) if specifically requested.

I give my permission to release information concerning

Name of Insured (First, Middle, Last)	Insured's Date of Birth	Insured's Social Security Number
	MM DD YYYY	
Date of Death	Contract Number(s)	

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 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 subect 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.

Please Print Name:		
Signature X	Relationship to Insured*	Date

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

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6. Medical Information

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

Other Life Insurance in effect for the Insured

Company Name:	Policy Number:
Company Name:	Policy Number:

Physicians and Hospitals where the Insured was treated

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, City, State, Zip		
Telephone	Dates treated	Condition(s)
Physician/Hospital:		
Address, City, State, Zip		
Telephone	Dates treated	Condition(s)
Physician/Hospital:		
Address, City, State, Zip		
Telephone	Dates treated	Condition(s)

Health Insurance policies that covered the Insured

Please list all health insurance carriers during the past 5 years.
❑ **Check here if a separate sheet is attached with additional carriers.**

Company Name:	Address, City, State, Zip	
Telephone	Policy Number	Effective Date
Company Name:	Address, City, State, Zip	
Telephone	Policy Number	Effective Date
Company Name:	Address, City, State, Zip	
Telephone	Policy Number	Effective Date

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 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.

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.

New York 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 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.

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 and 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.

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