LIFE INSURANCE COMPANY OF BOSTON & NEW YORK

HOME OFFICE: 4300 Camp Road, PO Box 331 • Athol Springs, NY 14010
SERVICE ADDRESS: PO Box 219 • Canton MA 02021
TEL (877) 274-1958 FAX 781-770-0492

LIFE INSURANCE COMPANY OF BOSTON & NEW YORK
FAMILY MATTERS. NO MATTER WHAT.

DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM KIT

INSTRUCTIONS FOR FILING A DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM

You may be eligible for benefits following a waiting period. If you anticipate that your disability will extend beyond the waiting period, please submit your claim now.

Be sure to continue to pay premiums until a decision is made on your claim.

1. Please complete **all sections** of the claim form.
   - Policyholder's statement of claim
   - Description of occupation
   - Educational/Work Experience

2. Please complete the **top section** of the Attending Physician's Statement. **(Name, Social Security Number and Policy Number)**

   Please give the Attending Physician's Statement to your doctor to complete.

   Your attending physician should fully complete both pages of the Attending Physician's Statement. A physician who can certify your total disability should complete this section.

3. Please complete the HIPAA authorization form.

Please be sure to fully complete all forms to prevent unnecessary delays in processing your claim.

If you should need assistance in the completion of the claim form

Please call (877) 274-1958

For Disability Income: Option 1 – For Waiver of Premium: Option 2

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POLICYHOLDER'S STATEMENT OF CLAIM

(If you need more space, please use the back of this form)

Insured's Name *(all known names)* _____

Social Security No. _____ Date of Birth _____ Telephone No. _____

Home Address _____
Street *City or Town* *State* *Zip Code*

Policy Number(s) _____

Last day worked _____ When did your disability start? _____ When do you expect to return to work? _____

Nature of Illness or Injury _____

If Accident - Date and Time _____ Place _____

Did Accident occur at work? _____ When did you first know you had this condition? _____

How did injury occur? _____

If pregnant, provide due date: _____

If hospitalized, give name and address of hospital(s) _____

_____

Dates confined to hospital(s) _____

Name of family physician, address and telephone number _____

Name of other physician(s), addresses and telephone numbers _____

Gross monthly income before disability $ _____ Current Monthly Income $ _____

	Applied	Date	Denied	Appealing	Company/Agency – Claim No.
Worker's Compensation	❑		❑	❑	
Social Security	❑		❑	❑	
Other Disability Benefits *(Group, LDT, etc.)*	❑		❑	❑	
State Disability	❑		❑	❑	
Retirement or Pension Plan	❑		❑	❑	
Private Insurance Plan	❑		❑	❑	
Other	❑		❑	❑	

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, consumer reporting agency, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Life Insurance Company of Boston & New York, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Life Insurance Company of Boston & New York to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Life Insurance Company of Boston & New York to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Life Insurance Company of Boston & New York to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Life Insurance Company of Boston New York Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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.

X _____ _____
Signature Date

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DESCRIPTION OF OCCUPATION

Insured's Name: _____ Policy No. _____

Please fully describe the occupational duties that you were performing immediately prior to your disability.

Employer: _____ Telephone No: (___) _____ Date of Hire _____

Employer's Address: _____

Normal hours worked each week: From _____ To _____ Your job title: _____

How many years have you worked in this occupation? _____ How long have you performed the duties listed below? _____

Your monthly earned income immediately preceding your disability: _____

Do you have any other part time jobs? YES ❑ NO ❑ If yes, please explain. _____

DAILY OCCUPATIONAL DUTIES

List and describe the most important duties first	Hours per week
1.	
2.	
3.	
4.	
5.	

INSTRUMENTS AND EQUIPMENT USED

List those used most frequently first	Hours per week
1.	
2.	
3.	
4.	
5.	

Where do you work? Mostly indoors ❑ Mostly outdoors ❑ Equally in and out ❑

If there is any additional information about your job that you believe will help us to understand the occupational duties you were performing, please explain *(use back of this form if necessary).*

PHYSICAL REQUIREMENTS OF YOUR OCCUPATION

	Occasionally	Frequently	Constantly
Bending	❑	❑	❑
Reaching	❑	❑	❑
Lifting	❑	❑	❑
Carrying	❑	❑	❑

Maximum weight you lift or carry:	10 lbs ❑	20 lbs ❑	50 lbs ❑	100 lbs ❑
Maximum weight you most frequently lift or carry:	10 lbs ❑	20 lbs ❑	50 lbs ❑	100 lbs ❑

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EDUCATION / WORK EXPERIENCE

Insured's Name: _____ Policy No: _____

Please complete this form to the best of your ability. Use an additional sheet of paper is you need more space.

EDUCATIONAL BACKGROUND

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED

Did you attend college or other school of higher learning? YES ❑ NO ❑

If yes, name of institution: _____

Degree(s) or Certificate(s): _____

Major field(s) of study: _____

WORK EXPERIENCE

List chronologically the jobs you have had as an adult and indicate:

1. Type of work. Be specific: *i.e. sales, accountant, clerk, laborer, etc.*
2. Physical Requirements: *i.e. heavy lifting, standing, sitting, etc.*
3. Supervisory Experience

Dates	Type of Work	Physical Requirements	Supervisory Experience
			YES ❑ NO ❑
			YES ❑ NO ❑
			YES ❑ NO ❑
			YES ❑ NO ❑

Additional courses taken, special skills, or hobbies. *Please be specific, such as carpentry, auto repair, etc.*

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X _____ _____
Signature Date

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ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY INSURED

Insured: _____ **Social Security No:** _____ **Policy No:** _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

HISTORY

Patient's symptoms result from *(check all that apply)*

❑ Employment ❑ Illness ❑ Pregnancy (Due Date: _____) ❑ Auto Accident ❑ Other Accident

Date Symptoms first appeared or date of accident/injury: _____ Date total disability commenced: _____

Date patient first consulted you for this condition: _____ Date of most recent visit: _____

Frequency of visits: ❑ Weekly ❑ Monthly Other *(please specify)* _____

Has patient had same or similar condition: ❑ YES ❑ NO If yes, Please explain: _____

Name(s) and addresses of other treating or referring physician(s) _____

_____

Hospital name: _____ Confinement Dates: _____ thru _____

DIAGNOSIS

Diagnosis *(including any complications or secondary diagnoses)* _____

Subjective Symptoms: _____

Objective finding *(include results/copies of x-rays, lab tests, EKGs, MRIs and scans)* _____

TREATMENT & PROGRESS

Please describe present treatment plan: *(including surgery, physical therapy or psychotherapy)*

_____

_____

Please advise all medications prescribed:

_____

_____

IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING HER/HIS OCCUPATION? ❑ YES ❑ NO

IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING ANY OCCUPATION? ❑ YES ❑ NO

When was or will patient be able to resume ANY PART of her/his work? _____

When was or will patient be able to resume ALL of her/his work? _____

Please describe any temporary restrictions and/or any return to work plan: _____

_____

CARDIAC

(Complete only if applicable)

Functional Capacity:

❑ Class 1 *(no limitation)* ❑ Class 2 *(slight limitation)* ❑ Class 3 *(marked limitation)* ❑ Class 4 *(complete limitation)*

Blood Pressure *(latest reading)* _____ as of *(date)* _____

Is patient in a cardiac rehabilitation program? ❑ YES ❑ NO

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CONTINUATION OF ATTENDING PHYSICIAN'S STATEMENT

Insured: _____ **Social Security No:** _____ **Policy No:** _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICAL IMPAIRMENT

(Complete only if applicable)

- ❑ **CLASS 1 –** No limitation of functional capacity; capable of heavy work. No restrictions. **0 -10%**
- ❑ **CLASS 2 –** Medium manual activity. **15 -30%**
- ❑ **CLASS 3 –** Slight limitation of functional capacity; capable of light work. **35 -55%**
- ❑ **CLASS 4 –** Moderate limitation of functional capacity; capable of clerical/administrative *(sedentary)* activity. **60 -70%**
- ❑ **CLASS 5 –** Severe limitation of functional capacity; incapable of minimal *(sedentary)* activity. **75 -100%**

Remarks: _____

PSYCHIATRIC IMPAIRMENT

(Complete only if applicable)

a) Please define "stress" as it applies to this claimant. _____

b) What stress and problems in interpersonal relations has claimant had on job? _____

- ❑ **CLASS 1 –** No limitation of functional capacity; capable of heavy work. No restrictions. **0 -10%**
- ❑ **CLASS 2 –** Medium manual activity. **15 -30%**
- ❑ **CLASS 3 –** Slight limitation of functional capacity; capable of light work. **35 -55%**
- ❑ **CLASS 4 –** Moderate limitation of functional capacity; capable of clerical/administrative *(sedentary)* activity. **60 -70%**
- ❑ **CLASS 5 –** Severe limitation of functional capacity; incapable of minimal *(sedentary)* activity. **75 -100%**

Remarks: _____

PROGNOSIS

Prognosis: ❑ Terminal ❑ Poor ❑ Good ❑ Excellent

Has patient reached maximum medical improvement? ❑ YES ❑ NO

When could trial of employment commence: Part-Time _____ Full-Time _____

REHABILITATION

Is patient a suitable candidate for rehabilitation services? ❑ YES ❑ NO

Please Explain: _____

Would job modification enable patient to work with impairment? ❑ YES ❑ NO

Please Explain: _____

Would vocational counseling and/or retraining be recommended? ❑ YES ❑ NO

Please Explain: _____

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.

X _____ _____
Signature Date

Physician's Name: _____ Degree or Specialty: _____

Address: _____
Street *City or Town* *State* *Zip Code*

Telephone Number: (____) _____ Fax Number: (____) _____

Signature: _____ Date: _____

LIFE INSURANCE COMPANY OF BOSTON & NEW YORK

4300 CAMP ROAD - PO BOX 331 • ATHOL SPRINGS, NY 14010
Service Address: PO Box 219 • Canton, MA 02021 • 800-645-2317

Authorization for Release of Health-Related Information To LIFE INSURANCE COMPANY OF BOSTON & NEW YORK

(This authorization complies with the HIPAA Privacy Rule)

Name of (Proposed) Insured/Patient (please print) _____ Date of Birth ___/___/___

Name of Second (Proposed) Insured/Patient (please print) _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Life Insurance Company of Boston & New York *(LICOBNY)* and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus *(HIV)* infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that LICOBNY may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with LICOBNY.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to LICOBNY at P.O. Box 219, Canton, MA 02021-0219, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that LICOBNY has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, LICOBNY may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of LICOBNY's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ the beneficiary(ies) of this Life Insurance Company of Boston & New York policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____

NOTICE OF INFORMATION PRIVACY PRACTICES

Life Insurance Company of Boston & New York

(Herein referred to as "we", "us", "our")

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- *Information we collect may include all the information you share with us including, for example, your*:
- name
- address
- telephone number
- date of birth
- social security or tax identification number
- employer name and income
- beneficiary data
- financial account numbers
- medical information
- and other information you share with us
- *We may also collect data we receive from other sources, as allowed by law, which may include:*
- medical information
- consumer report information in accordance with the Fair Credit Reporting Act
- participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
- information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- *We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:*
- process or service your insurance transactions with us
- perform underwriting, administrative, account maintenance and claims functions
- provide customer service or reinsurance coverage
- prevent fraud
- perform other business functions on our behalf
- *We may also share your information with:*
- a consumer reporting agency in accordance with the Fair Credit Reporting Act
- a third party to comply with federal, state or local laws, subpoenas, or summonses
- regulators
- or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Life Insurance Company of Boston & New York
Attention: Privacy Office
4300 Camp Road / PO Box 331 / Athol Springs, NY 14010