

**LIFE INSURANCE COMPANY OF BOSTON & NEW YORK**

HOME OFFICE: 60 Main Street, Suite 4 • Hamburg, NY 14075

SERVICE ADDRESS: PO Box 219 • Canton MA 02021 • TEL 877-274-1958 FAX 781-770-0492



**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**



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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                               | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| Social Security                                     | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| Other Disability Benefits <i>(Group, LDT, etc.)</i> | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| State Disability                                    | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| Retirement or Pension Plan                          | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| Private Insurance Plan                              | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |
| Other                                               | <input type="checkbox"/> |      | <input type="checkbox"/> | <input type="checkbox"/> |                            |

**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                                           | <input type="checkbox"/>        | <input type="checkbox"/>        | <input type="checkbox"/>        |                                  |
| Reaching                                          | <input type="checkbox"/>        | <input type="checkbox"/>        | <input type="checkbox"/>        |                                  |
| Lifting                                           | <input type="checkbox"/>        | <input type="checkbox"/>        | <input type="checkbox"/>        |                                  |
| Carrying                                          | <input type="checkbox"/>        | <input type="checkbox"/>        | <input type="checkbox"/>        |                                  |
| <hr/>                                             |                                 |                                 |                                 |                                  |
| Maximum weight you lift or carry:                 | 10 lbs <input type="checkbox"/> | 20 lbs <input type="checkbox"/> | 50 lbs <input type="checkbox"/> | 100 lbs <input type="checkbox"/> |
| Maximum weight you most frequently lift or carry: | 10 lbs <input type="checkbox"/> | 20 lbs <input type="checkbox"/> | 50 lbs <input type="checkbox"/> | 100 lbs <input type="checkbox"/> |

**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.**

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Signature Date

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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 if 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 <input type="checkbox"/> | NO <input type="checkbox"/> |
|       |              |                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|       |              |                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|       |              |                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|       |              |                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

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

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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**

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>HISTORY</b> | Patient's symptoms result from ( <i>check all that apply</i> )<br><input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy (Due Date: _____) <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident<br>Date Symptoms first appeared or date of accident/injury: _____ Date total disability commenced: _____<br>Date patient first consulted you for this condition: _____ Date of most recent visit: _____<br>Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly    Other ( <i>please specify</i> ) _____<br>Has patient had same or similar condition: <input type="checkbox"/> YES <input type="checkbox"/> NO    If yes, Please explain: _____<br>Name(s) and addresses of other treating or referring physician(s) _____<br>_____<br>Hospital name: _____ Confinement Dates: _____ thru _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                | <b>DIAGNOSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Diagnosis ( <i>including any complications or secondary diagnoses</i> ) _____<br>Subjective Symptoms: _____<br>Objective finding ( <i>include results/copies of x-rays, lab tests, EKGs, MRIs and scans</i> ) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                | <b>TREATMENT &amp; PROGRESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Please describe present treatment plan: ( <i>including surgery, physical therapy or psychotherapy</i> )<br>_____<br>_____<br>Please advise all medications prescribed:<br>_____<br>_____<br>IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING <u>HER/HIS</u> OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING ANY OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>When was or will patient be able to resume ANY PART of her/his work? _____<br>When was or will patient be able to resume ALL of her/his work? _____<br>Please describe any temporary restrictions and/or any return to work plan: _____<br>_____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>CARDIAC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ( <b>Complete only if applicable</b> )<br><b>Functional Capacity:</b><br><input type="checkbox"/> Class 1 ( <i>no limitation</i> ) <input type="checkbox"/> Class 2 ( <i>slight limitation</i> ) <input type="checkbox"/> Class 3 ( <i>marked limitation</i> ) <input type="checkbox"/> Class 4 ( <i>complete limitation</i> )<br>Blood Pressure ( <i>latest reading</i> ) _____ as of ( <i>date</i> ) _____<br>Is patient in a cardiac rehabilitation program? <input type="checkbox"/> YES <input type="checkbox"/> NO |

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## CONTINUATION OF ATTENDING PHYSICIAN'S STATEMENT

**Insured:** \_\_\_\_\_ **Social Security No:** \_\_\_\_\_ **Policy No:** \_\_\_\_\_

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>PHYSICAL IMPAIRMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p><b>(Complete only if applicable)</b></p> <p><input type="checkbox"/> <b>CLASS 1</b> – No limitation of functional capacity; capable of heavy work. No restrictions. <b>0 -10%</b></p> <p><input type="checkbox"/> <b>CLASS 2</b> – Medium manual activity. <b>15 -30%</b></p> <p><input type="checkbox"/> <b>CLASS 3</b> – Slight limitation of functional capacity; capable of light work. <b>35 -55%</b></p> <p><input type="checkbox"/> <b>CLASS 4</b> – Moderate limitation of functional capacity; capable of clerical/administrative (<i>sedentary</i>) activity. <b>60 -70%</b></p> <p><input type="checkbox"/> <b>CLASS 5</b> – Severe limitation of functional capacity; incapable of minimal (<i>sedentary</i>) activity. <b>75 -100%</b></p> <p>Remarks: _____</p>                                                                                                                                                                     |
| <b>PSYCHIATRIC IMPAIRMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p><b>(Complete only if applicable)</b></p> <p>a) Please define "stress" as it applies to this claimant. _____</p> <p>b) What stress and problems in interpersonal relations has claimant had on job? _____</p> <p><input type="checkbox"/> <b>CLASS 1</b> – No limitation of functional capacity; capable of heavy work. No restrictions. <b>0 -10%</b></p> <p><input type="checkbox"/> <b>CLASS 2</b> – Medium manual activity. <b>15 -30%</b></p> <p><input type="checkbox"/> <b>CLASS 3</b> – Slight limitation of functional capacity; capable of light work. <b>35 -55%</b></p> <p><input type="checkbox"/> <b>CLASS 4</b> – Moderate limitation of functional capacity; capable of clerical/administrative (<i>sedentary</i>) activity. <b>60 -70%</b></p> <p><input type="checkbox"/> <b>CLASS 5</b> – Severe limitation of functional capacity; incapable of minimal (<i>sedentary</i>) activity. <b>75 -100%</b></p> <p>Remarks: _____</p> |
| <b>PROGNOSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Prognosis:      <input type="checkbox"/> Terminal      <input type="checkbox"/> Poor      <input type="checkbox"/> Good      <input type="checkbox"/> Excellent</p> <p>Has patient reached maximum medical improvement?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>When could trial of employment commence:    Part-Time _____      Full-Time _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>REHABILITATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>Is patient a suitable candidate for rehabilitation services?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>Please Explain: _____</p> <p>Would job modification enable patient to work with impairment?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>Please Explain: _____</p> <p>Would vocational counseling and/or retraining be recommended?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>Please Explain: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>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.</b></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p>X _____ Date _____</p> <p>Signature _____ Date _____</p> <p>Physician's Name: _____ Degree or Specialty: _____</p> <p>Address: _____</p> <p style="text-align: center;">Street City or Town State Zip Code</p> <p>Telephone Number: ( ) _____ Fax Number: ( ) _____</p> <p>Signature: _____ Date: _____</p>                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

# 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
- prevent fraud
- or perform other business functions on our behalf
- provide customer service or reinsurance coverage

▶ ***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  
60 Main Street / Suite 4 / Hamburg, NY 14075



**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