

COMBINED LIFE INSURANCE COMPANY OF NEW YORK

11 British American Boulevard, Latham, New York 12110

CLAIM NUMBER

NAME ADDRESS

IMPORTANT INSTRUCTIONS FOR FILING CLAIM

1. ONLY THIS ONE FORM IS NECESSARY FOR ALL POLICIES.
2. IF LOSS OF TIME IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE STATEMENT ON REVERSE SIDE.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.
4. PLEASE RETURN THIS FORM AFTER YOU HAVE BEEN DISABLED 30 DAYS OR WHEN YOU RETURN TO WORK, WHICHEVER OCCURS FIRST. DO NOT WAIT UNTIL YOU ARE MEDICALLY DISCHARGED. ADDITIONAL FORMS WILL BE SENT FOR CONTINUING DISABILITY.

PLEASE PRINT—DO NOT WRITE

CLAIMANT'S FULL NAME MR. MRS. MISS				AREA CODE	HOME PHONE	BUSINESS PHONE
ADDRESS (Street and No.) (City) (State) (Zip)				POLICY NUMBER(S) a)	FORM NUMBER(S) a)	LAST PAYMENT DATE a) 19
BIRTH DATE MO. DAY YR.	HEIGHT	WEIGHT		b)	b)	b) 19
OCCUPATION	SOC. SEC. NO.			c)	c)	c) 19
EMPLOYER'S NAME				d)	d)	d) 19
EMPLOYER'S ADDRESS				ARE YOU ALSO FILING CLAIM UNDER WORKERS' COMP. ACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		

IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME

IF CLAIM IS FOR SICKNESS PLEASE COMPLETE	DATE OF FIRST SYMPTOMS 19	HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE DATE. 19
	NATURE OF SICKNESS		

IF CLAIM IS FOR ACCIDENT PLEASE COMPLETE	DATE OF ACCIDENT 19	TIME OF ACCIDENT AM PM	NATURE OF INJURIES
	PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED		
	WHAT WERE YOU DOING WHEN ACCIDENT OCCURRED?		
	PLEASE DESCRIBE IN DETAIL HOW ACCIDENT OCCURRED		

PLEASE COMPLETE FOR BOTH ACCIDENT AND SICKNESS CLAIMS	HOSPITAL'S NAME AND ADDRESS AND CONFINEMENT DATES FROM 19 TO 19		
	ATTENDING PHYSICIANS' NAMES AND ADDRESSES		DATES OF TREATMENT
	A) TOTAL DISABILITY: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES? A) FROM 19 THROUGH 19 B) DATE RETURNED TO WORK B) 19 C) PARTIAL DISABILITY: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES? C) FROM 19 THROUGH 19		

WOULD IT BE ALL RIGHT IF, DURING THE NEXT YEAR, WE MENTION YOUR CLAIM BENEFITS WHEN TALKING TO PROSPECTIVE POLICYHOLDERS ABOUT OUR CLAIM SERVICE? YES NO THANK YOU.

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, 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.

DATED: 19
400641R

SIGNED: **X**
CLAIMANT'S SIGNATURE (If Minor, Parent's Signature) R. 10/98

AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, insurance company, employer or consumer reporting agency to release to Combined Life Insurance Company of New York any information concerning my health for the purpose of processing a claim. Combined is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATED: 19

SIGNED: **X**
CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

EMPLOYER'S STATEMENT (IF STUDENT, PLEASE HAVE SCHOOL PRINCIPAL COMPLETE)

EMPLOYEE'S NAME		WORKERS' COMP. CLAIM FILED FOR THIS DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF COMPENSATION CARRIER
TOTAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ALL DUTIES? FROM 19..... TO 19.....			DATE RETURNED TO WORK (OR SCHOOL) 19.....
PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES? FROM 19..... TO 19.....			
DATE	TITLE	SIGNATURE	TELEPHONE

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	ADDRESS	CITY-STATE-ZIP CODE	AGE
DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)			
1. NATURE AND ORIGIN OF:	<input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY CONFIRMED BY X-RAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	DATE 19.....		
3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE 19.....		
4. HOW DID CONDITION ORIGINATE?			
5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES," STATE WHEN AND DESCRIBE.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.			
7. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCRIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)	DATES: 19.....		CLOSED REDUCTION?
	APPROACH USED:		OPEN REDUCTION?
8. GIVE DATES OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.	NATURE OF TREATMENT		
	OFFICE		
	HOME		
9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY.	<input type="checkbox"/> YES <input type="checkbox"/> NO		RECOVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DATE 19.....		
10. IF PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL.	HOSPITAL	CITY	STATE
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?	FROM 19..... THROUGH 19.....		
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	FROM 19..... THROUGH 19.....		
13. WAS PATIENT CONFINED TO THE HOUSE? (IF "YES," GIVE DATES.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	FROM 19..... THROUGH 19.....		

PHYSICIAN'S SIGNATURE		DEGREE
COMPLETE ADDRESS		
DATE	TELEPHONE	
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE		
INDIVIDUAL PRACTITIONER'S S.S. NO.		ALL OTHERS - EMPLOYER I.D. NO.
+ + + + +		+ + + + +