Dear Member:

As requested, enclosed is a claim form for your ABE Hospital Indemnity Insurance Program. It must be completed in full. In addition, the following information **MUST** be sent with the claim form and mailed to the ABE:

1. A copy of all inpatient hospital statements that show the admission, discharge dates and diagnosis codes **MUST** be attached to the claim form. If the hospital statement does not include diagnosis codes, a signed doctor's statement with diagnosis codes must be included. A Primary Insurance benefit statement *cannot* be used in place of the hospital statement or doctor's statement.

2. If you are insured under the "Surgical Benefit" you **MUST** include the operative report and a copy of the itemized surgical bill including CPT or any diagnosis codes, with a description of the procedure. A Primary Insurance benefit statement *cannot* be used in place of a surgeon's bill or operative report.

3. If you were hospitalized for a one day stay and the stay was 18 hours or longer, this **MUST** be indicated on the hospital bill. If your hospital stay was less than 18 hours, no daily benefit will be paid. (Note: Your plan pays per day from the first day of hospitalization up to a maximum of 365 days.)

Proof of Loss: The Endowment or New York Life must receive satisfactory proof of the loss within 90 days after the date of loss. Failure to furnish such proof within such time shall niether invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible.

If you have any questions, please feel free to contact your Personal Endowment Representative at 800-621-8981.

Sincerely,

Bonnie M. Gorsky

Supervisor, Insurance Administration

Enclosure

P.S. Please note, your claim will be delayed if the hospital statement and/or doctor's statement (if "Surgical Benefit" is applicable), operative report, and surgeon's itemized statement are not attached to the completed claim form.

10/99

HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS:

- *The Administrator will complete the Policyholder Statement section. You should complete all remaining sections and sign the Member Certification.* ***COMPLETION*** *of the entire form speeds claims processing.*
- *Please make sure that you sign the Authorization for Release of Information on the reverse side of this form.*
- *Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.*

– MAIL COMPLETED FORM AND HOSPITAL BILL TO:
AMERICAN BAR ENDOWMENT
321 NORTH CLARK STREET
CHICAGO, IL 60654-7648
(800) 621-8981

CLAIM PROCESSING INFORMATION (COMPLETED BY MEMBER)

▶ MEMBER'S LAST NAME: FIRST NAME: INITIAL:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

DAYTIME TELEPHONE NUMBER:
( ) –

▶ DATE OF BIRTH: MONTH_____ DAY_____ YEAR____ ▶ SEX: ❑ MALE ❑ FEMALE
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS? ☐ YES ☐ NO
IF YES, PROVIDE INFORMATION REQUESTED BELOW:
OTHER CARRIER'S NAME
ADDRESS: ____________________
TELEPHONE NUMBER: ____________________
NAME OF COVERED PERSON: ____________________
PLAN NUMBER: ____________________

▶ ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
MO_________ DY_________ YR_________

▶ ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
MO_________ DY_________ YR_________

SOCIAL SECURITY NUMBER:
___ ___ ___ / ___ ___ / ___ ___ ___ ___

▶ NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT

NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

DATES OF HOSPITAL CONFINEMENT:
FROM__________ TO__________
FROM__________ TO__________
FROM__________ TO__________

NATURE OF SICKNESS OR INJURY:

PATIENT INFORMATION (COMPLETED BY MEMBER ONLY FOR DEPENDENT CLAIMS)

▶ PATIENT LAST NAME: FIRST NAME: INITIAL:

STREET ADDRESS (IF DIFFERENT FROM MEMBER'S ADDRESS):

CITY: STATE: ZIP CODE:

▶ PATIENT RELATIONSHIP TO MEMBER:
❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ OTHER__________

▶ PATIENT SEX: ❑ MALE ❑ FEMALE
▶ DATE OF BIRTH: MONTH_______ DAY_______ YEAR_______
▶ SOCIAL SECURITY NUMBER: ___ ___ ___/___ ___/___ ___ ___ ___
▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:
MARRIED? ❑ YES ❑ NO
EMPLOYED? ❑ YES ❑ NO
IN THE MILITARY? ❑ YES ❑ NO
FEDERAL EMPLOYEE? ❑ YES ❑ NO

MEMBER CERTIFICATION (COMPLETED BY MEMBER)

PLEASE NOTE: **ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.**

I CERTIFY THAT THE CLAIM PROCESSING AND PATIENT INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE____________________ DATE__________
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

POLICYHOLDER STATEMENT (COMPLETED BY ADMINISTRATOR)

▶ MEMBER'S LAST NAME: FIRST NAME: INITIAL:

SEX: ❑ MALE ❑ FEMALE DATE OF BIRTH
MO_______ DY_______ YR_______

▶ MEMBER'S INSURANCE EFFECTIVE DATE: MO_______ DY_______ YR_______

▶ MEMBER'S PAID TO DATE: MO_______ DY_______ YR_______

▶ CERTIFICATE HOLDER ID:____________________

▶ NAME OF POLICYHOLDER:____________________

▶ GROUP POLICY NUMBER:
G-11459

AMOUNT OF DAILY BENEFIT:
$__________

▶ CANCER/ICU BENEFIT ❑ YES ❑ NO
▶ SURGICAL BENEFIT ❑ YES ❑ NO
▶ (INDICATE APPLICABLE BENEFIT)
❑ $1000 ❑ $2000

▶ DOES THIS MEMBER HAVE DEPENDENTS' INSURANCE? ❑ YES ❑ NO
IF YES, ❑ SPOUSE ❑ CHILDREN

▶ DEPENDENTS' INSURANCE EFFECTIVE DATE: MO_____ DY_____ YR_____
(IF APPLICABLE)

▶ AMOUNT OF DAILY BENEFIT (DEPENDENT) $__________

▶ DEPENDENT'S PAID TO DATE: MO_____ DY_____ YR_____

▶ I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

DATE SIGNED:__________ BY:____________________
(AUTHORIZED REPRESENTATIVE) (TITLE)

AUTHORIZATION FOR RELEASE OF INFORMATION (COMPLETED BY PATIENT)

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

______________________________ PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR)

______________________________ DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT:
MO DY YR
____/____/____

❑ ILLNESS (FIRST SYMPTOM) OR
❑ INJURY (ACCIDENT) OR
❑ PREGNANCY (LMP)

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ❑ YES ❑ NO

IF YES, GIVE FIRST DATE:
MO DY YR
____/____/____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MO DY YR ____/____/____ THROUGH MO DY YR ____/____/____

NAME OF REFERRING PHYSICIAN

____
____
____

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

____
____
____

____
FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS

SIGNED______________________________ DATE__________________

DATE FIRST CONSULTED YOU FOR
THIS CONDITION MO DAY Y R
____/____/____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

1.______________________________

2.______________________________

3.______________________________

4.______________________________

IS CONDITION DUE TO PREGNANCY?
❑ YES ❑ NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.
MO DY YR
____/____/____

PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.