AMERICAN BAR ENDOWMENT

More than 75 years of service

Dear Member:

The claim form for your ABE – Sponsored Hospital Money Insurance Plan must be completed in full. In addition, the following information **MUST** be sent along with the claim form and mailed to New York Life Insurance Company, Group Membership Association Claims, PO Box 228, White Plains, NY 10602-9905 .

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 the 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 Insurance Company must receive satisfactory proof of the loss within 90 days after the date of loss. Failure to furnish such proof within such time shall not 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 1-800-621-8981 or email us at information@abendowment.org.

Sincerely,

Bonnie M Czarny, ACS, AIAA
Manager
Insurance Administration

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

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 claim.
— Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:
NEW YORK LIFE INSURANCE COMPANY
GROUP MEMBERSHIP ASSOCIATION CLAIMS
PO BOX 228 WHITE PLAINS, NY 10602-9905

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?
MONTH_____ DAY_____ YEAR_____

► 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:

► ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
MONTH_____ DAY_____ YEAR_____

PATIENT INFORMATION

► LAST NAME: FIRST NAME: INITIAL:

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

CITY: STATE: ZIP CODE:

► PATIENT'S 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

I CERTIFY: I HAVE READ AND UNDERSTAND THE FRAUD STATEMENT THAT IS APPLICABLE TO THE STATE IN WHICH I RESIDE. 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.

New York Residents: 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**.**

I CERTIFY THAT THE 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: MONTH_____DAY_____YEAR_____

► MEMBER'S INSURANCE EFFECTIVE DATE: MONTH_____ DAY_____YEAR_____

► MEMBER'S PAID TO DATE: MONTH_____ DAY_____YEAR_____

► CERTIFICATE HOLDER ID:

► NAME OF POLICYHOLDER:

► I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY

► GROUP POLICY NUMBER: G-11459

AMOUNT OF DAILY BENEFIT:
$

► CANCER/ICU BENFIT: ☐YES ☐NO

► SURGICAL BENEFIT: ☐YES ☐NO

► (INDICATE APPLICABLE BENEFIT):
☐ $1000 ☐ $2000

► DOES THIS MEMBER HAVE DEPENDENT'S INSURANCE? ☐YES ☐NO

IF YES, ☐ SPOUSE ☐ CHILDREN

► DEPENDENT'S INSURANCE EFFECTIVE DATE: MO_____ DY_____ YR_____
(IF APPLICABLE)

► AMOUNT OF DAILY BENEFIT (DEPENDENT): $_____

►DEPENDENT'S PAID TO DATE: MO_____ DY_____ YR_____

DATE SIGNED: _____ BY: _____

22039 (4/19) ABE (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'S/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)

DATE FIRST CONSULTED YOU FOR THIS CONDITION:
MO DY YR
_____/ _____/ _____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐YES ☐NO
IF YES, GIVE FIRST DATE: MO DY YR
_____/ _____/ _____

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

NAME OF REFERRING PHYSICIAN

_____

_____

_____

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

_____

_____

_____

_____

_____

FEDERAL TAX I.D. NUMBER SSN EIN

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
_____/ _____/ _____

SIGNATURE _____DATE _____

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

STATE FRAUD NOTICE

FOR ALABAMA RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof."

FOR ALASKA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR ARIZONA RESIDENTS
"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 the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the 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."

FOR CALIFORNIA RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

FOR COLORADO RESIDENTS
"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 claimant for the purpose of defrauding or attempting to defraud the 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."

FOR DELWARE RESIDENTS
"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR DISTRICT OF COLUMBIA RESIDENTS
"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant."

FOR FLORIDA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS
"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS
"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR INDIANA RESIDENTS
"A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony."

FOR KENTUCKY RESIDENTS
"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."

FOR LOUISIANA RESIDENTS
"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."

STATE FRAUD NOTICE

FOR MAINE RESIDENTS
"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 or denial of insurance benefits."

FOR MARYLAND RESIDENTS
"Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR MINNESOTSA RESIDENTS
"Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

FOR NEW HAMPSHIRE RESIDENTS
"Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

FOR NEW JERSEY RESIDENTS
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties in New Jersey."

FOR NEW MEXICO RESIDENTS
"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 civil crimes and criminal penalties."

FOR OHIO RESIDENTS
"Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of Insurance Fraud."

FOR OKLAHOMA RESIDENTS
WARNING: "Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony."

FOR OREGON RESIDENTS
"Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals, for purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud."

FOR PENNSYLVANIA 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 subjects such person to criminal and civil penalties."

FOR PUERTO RICO RESIDENTS
"Any person who, knowingly, and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with the fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

FOR TENNESSEE RESIDENTS
"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.

FOR TEXAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

FOR VERMONT 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."

FOR VIRGINIA RESIDENTS:
"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 or denial of insurance benefits."