



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: _____	▶ SOCIAL SECURITY NUMBER _____ / _____ / _____
STREET ADDRESS: _____	▶ NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT: _____
CITY: _____ STATE: _____ ZIP CODE _____	_____
DAYTIME TELEPHONE NUMBER: _____ () _____	_____
▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ ▶ SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	▶ NAME AND ADDRESS OF HOSPITAL WHERE CONFINED: _____
▶ MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	_____
▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS?	▶ DATES OF HOSPITAL CONFINEMENT: FROM _____ TO _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	FROM _____ TO _____
IF YES, PROVIDE INFORMATION REQUESTED BELOW:	▶ NATURE OF SICKNESS OR INJURY: _____
OTHER CARRIER'S NAME: _____	_____
ADDRESS: _____	▶ ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
TELEPHONE NUMBER: _____	MONTH ___ DAY ___ YEAR ___
NAME OF COVERED PERSON: _____	
PLAN NUMBER: _____	
▶ ON WHAT DATE DID SYMPTOMS FIRST APPEAR?	
MONTH ___ DAY ___ YEAR ___	

PATIENT INFORMATION

▶ LAST NAME: _____ FIRST NAME: _____ INITIAL: _____	▶ PATIENT SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
▶ STREET ADDRESS: (IF DIFFERENT FROM MEMBER'S ADDRESS) _____	▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___
CITY: _____ STATE: _____ ZIP CODE: _____	▶ SOCIAL SECURITY NUMBER _____ / _____ / _____
▶ PATIENT'S RELATIONSHIP TO MEMBER:	▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:
<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER _____	MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO
	EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
	IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO
	FEDERAL EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> 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: _____	▶ GROUP POLICY NUMBER: _____	▶ CANCER/ICU BENEFIT: <input type="checkbox"/> YES <input type="checkbox"/> NO
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___	G-11459	▶ SURGICAL BENEFIT: <input type="checkbox"/> YES <input type="checkbox"/> NO
▶ MEMBER'S INSURANCE EFFECTIVE DATE: MONTH ___ DAY ___ YEAR ___	AMOUNT OF DAILY BENEFIT: \$ _____	▶ (INDICATE APPLICABLE BENEFIT): <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000
▶ MEMBER'S PAID TO DATE: MONTH ___ DAY ___ YEAR ___	▶ DOES THIS MEMBER HAVE DEPENDENT'S INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
▶ CERTIFICATE HOLDER ID: _____	IF YES, <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN	
▶ NAME OF POLICYHOLDER: _____	▶ DEPENDENT'S INSURANCE EFFECTIVE DATE: MO ___ DY ___ YR ___	
	(IF APPLICABLE)	
▶ I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY	▶ 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)

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

____/____/____

1. _____

DATE FIRST CONSULTED YOU FOR THIS CONDITION:
MO DY YR

2. _____

____/____/____

3. _____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

IF YES, GIVE FIRST DATE: MO DY YR

____/____/____

4. _____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:

MO DY YR MO DY YR

FROM ____/____/____ THROUGH ____/____/____

IS CONDITION DUE TO PREGNANCY? YES NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.

MO DY YR

____/____/____

NAME OF REFERRING PHYSICIAN

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

FEDERAL TAX I.D. NUMBER SSN EIN

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.