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

HOME OFFICE: 4300 Camp Road, PO Box 331 • Athol Springs, NY 14010
ADMINISTERED BY: NEW HORIZON BENEFIT ADMINISTRATORS, INC.
PO Box 34952 • Omaha, NE 68134-9832 – TEL 1-866-757-0794 • FAX 1-888-453-5127

LIFE INSURANCE COMPANY OF BOSTON&NEW YORK
FAMILY MATTERS. NO MATTER WHAT.

# ACCIDENT CLAIM FORM

## INSTRUCTIONS:

1. Please make sure all questions on this form are completed.
2. If we request an authorization form from you, please complete, sign and date the authorization form we've included.
3. For **Accident** claims, please attach itemized hospital bills, physician bills or medical records documenting the injuries and treatment received.
4. For **Sickness-Hospital Confinement** claims, please attach the itemized hospital bill and medical records documenting the reason for the confinement.
5. **Please mail all correspondence and completed claim form to PO Box 34952, Omaha NE 68134-9632 or fax to 1-888-453-5127.**

Policyowner's full name _____ Policy number _____

Address _____ Daytime telephone No. _____
STREET CITY STATE ZIP CODE

❑ Check if this is a new address Policyowner's Social Security No. _____

Mailing address *(if different)* _____

Name and telephone number of employer _____

Patient's full name _____ Date of birth _____ Relationship to policyowner _____

**PLEASE PROVIDE ALL INFORMATION REQUESTED ON THIS FORM TO AVOID ANY DELAYS IN THE PROCESSING OF YOUR CLAIM.**

## 1. COMPLETE THIS SECTION IF CLAIM IS FOR ACCIDENT:

Give the date of the accident ___/___/___ Location of accident _____

Explain how the accident happened *(if due to a motor vehicle accident, attach a copy of the accident report)* _____

List all injuries received _____

Did the accident occur while working for pay or profit? ❑ Yes ❑ No

If yes, was the accident covered by any state or federal worker's compensation, employer's liability or occupational disease law?
❑ Yes ❑ No

Name and address of treating physician _____

## 2. COMPLETE THIS SECTION IF FILING A CLAIM UNDER THE OPTIONAL SICKNESS-HOSPITAL CONFINEMENT BENEFIT RIDER:

Condition claim is being filed for _____

Date symptoms first noticed ___/___/___

Names and addresses of doctors seen _____

List the name and address of your regular or family physician _____

**For claim questions call toll free 1-866-757-0794**

3. Has patient had the same or similar condition before? ❑ Yes ❑ No If yes, give details _____

_____

_____

4. Has patient had other medical treatment during the past five years? ❑ Yes ❑ No
   If yes, describe conditions and list names and addresses of doctors consulted and dates seen _____

_____

_____

_____

5. Was patient hospitalized as a result of this claim? ❑ Yes ❑ No
   If yes, provide name and address of hospital _____

_____

_____

_____

Admission Date ___/___/___ Discharge Date ___/___/___

**WARNING: 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.**

I certify that the above statements are true and correct.

Date ___/___/___ Policyowner's signature _____

**For claim questions call toll free 1-866-757-0794**

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

4300 CAMP ROAD - PO BOX 331 • ATHOL SPRINGS, NY 14010
Service Address: PO Box 219 • Canton, MA 02021 • 800-645-2317

## 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 _____

# 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
- provide customer service or reinsurance coverage
- prevent fraud
- perform other business functions on our behalf
- *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
4300 Camp Road / PO Box 331 / Athol Springs, NY 14010