

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

HOME OFFICE: 4300 Camp Road, PO Box 331 • Athol Springs, NY 14010  
SERVICE ADDRESS: PO Box 219 • Canton MA 02021  
TEL (877) 274-1958 FAX 781-770-0492



**SPECIFIED DISEASE AND HEALTH SCREENING BENEFIT CLAIM KIT**

**INSTRUCTIONS FOR FILING A SPECIFIED DISEASE CLAIM**

1. Please complete Section 1 - Claimant's Statement.
2. Please complete Section 2 - Specified Disease Information. *(If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)*
3. Please read and sign the HIPAA compliant authorization. *(The authorization will help us obtain any additional medical information needed to complete the processing of your claim. By not completing the authorization, this could delay the processing of your claim.)*
4. Please have your attending physician complete Section 4, Attending Physician's Statement.

**INSTRUCTIONS FOR FILING A HEALTH SCREENING CLAIM**

1. Please complete Section 3 - Health Screening Claim form.
2. Attach medical documentation which indicates the type of test performed and the date the test was performed.

**If you should need assistance in the completion of this claim form  
Please call (877) 274-1958  
\* \* \* SEND COMPLETED CLAIM FORM TO ABOVE ADDRESS OR FAX TO (781) 770-0492 \* \* \***



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**SECTION 1 – CLAIMANT’S STATEMENT (Please Print)**

Insured Name (Last, First)		Social Security #	Date of Birth (mo-day-yr)	Policy #
Address (City, State, Zip)			Phone Number	
Patient’s Name	Relationship to Insured	Patient’s Date of Birth (mo-day-yr)	Patient’s Date of Death (if applicable)	

**SECTION 2 – SPECIFIED DISEASE INFORMATION**

**What is the specific Specified Disease: (Please check appropriate box)**

**Please note: Not all illnesses listed below are eligible for coverage. Please refer to your policy for a list of covered illnesses.**

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer/Carcinoma In Situ/Skin Cancer | <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS)   |
| <input type="checkbox"/> Myocardial Infarction (Heart Attack) | <input type="checkbox"/> Renal Failure (Kidney Failure)  |
| <input type="checkbox"/> Coronary Artery Bypass Surgery       | <input type="checkbox"/> Major Organ Transplant (Covered Organs: heart, lung, liver, kidney or pancreas) |
| <input type="checkbox"/> Alzheimer’s Disease                  | <input type="checkbox"/> Stroke  |

Date specified disease was diagnosed \_\_\_\_\_ Have you ever had the same or similar condition? YES  NO   
 If Yes, please explain \_\_\_\_\_

On what date did you first consult a medical practitioner in connection with your specified disease? \_\_\_\_\_

**Please indicate the name and address of the Physician seen:**

Name and Specialty: \_\_\_\_\_

Street Address: (City, State, Zip) \_\_\_\_\_

**Please provide the name and address of the Primary Care Physician:**

Name: \_\_\_\_\_

Street Address: (City, State, Zip) \_\_\_\_\_

**If the specified disease required hospitalization, provide the name and address of the treating facility and dates of confinement:**

Name of Facility: \_\_\_\_\_ Date Hospitalized from: \_\_\_\_\_ to \_\_\_\_\_

Street Address: (City, State, Zip) \_\_\_\_\_

**Please provide details of any other doctors or specialists who have been consulted in connection with this specified disease:**

<u>Name</u>	<u>Address</u>	<u>Dates Seen</u>
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**If policy has been in force less than 2 years, please provide the names and address of all physician’s, not mentioned above, that have been consulted in the past 5 years:**

<u>Name</u>	<u>Address</u>	<u>Dates Seen</u>
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**CERTIFICATION - Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete. 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.**

X \_\_\_\_\_  
 Signature of Claimant Printed Signature Date



**SECTION 3 - HEALTH SCREENING/GENETIC TESTING BENEFIT CLAIM KIT**

**INSTRUCTIONS FOR FILING A HEALTH SCREENING/GENETIC TESTING CLAIM**

1. Please complete Claimant's Statement.
2. Please complete Health Screening/Genetic Testing Information.
3. Please review, sign and date the form.
4. Attach medical documentation which indicates the type of test performed and the date the test was performed.

**CLAIMANT'S STATEMENT (Please Print)**

Insured Name ( <i>Last, First</i> )	Claimant's ( <i>Patient</i> ) Name	Policy #
Address ( <i>City, State, Zip</i> )		
Telephone Number	Claimant's Date of Birth ( <i>mo-day-yr</i> )	Insured's Social Security #

**HEALTH SCREENING/GENETIC TESTING INFORMATION**

**DATE TEST PERFORMED** \_\_\_\_\_

**WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED?**

- |   |  |
|---|--|
| <input type="checkbox"/> Stress Test on a Bicycle or Treadmill<br><input type="checkbox"/> Lipid Panel ( <i>Total Cholesterol Count</i> )<br><input type="checkbox"/> CA 15-3 ( <i>Blood Test for Breast Cancer</i> )<br><input type="checkbox"/> Serum Protein Electrophoresis ( <i>myeloma</i> )<br><input type="checkbox"/> CEA ( <i>Blood Test for Colon Cancer</i> )<br><input type="checkbox"/> PSA ( <i>Blood Test for Prostate Cancer</i> )<br><input type="checkbox"/> Fasting Blood Glucose Test<br><input type="checkbox"/> CA 125 ( <i>Blood Test for Ovarian Cancer</i> )<br><input type="checkbox"/> Hemocult Stool Analysis<br><input type="checkbox"/> GENETIC SCREENING TEST | <input type="checkbox"/> Thermography<br><input type="checkbox"/> Bone Marrow Testing<br><input type="checkbox"/> Mammography/Breast Ultrasound<br><input type="checkbox"/> Blood Test for Triglycerides<br><input type="checkbox"/> Flexible Sigmoidoscopy<br><input type="checkbox"/> Pap Smear ( <i>including ThinPrep Pap Test</i> )<br><input type="checkbox"/> Chest X-Ray<br><input type="checkbox"/> Colonoscopy |
|---|--|

**CERTIFICATION - Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete. 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.**

X \_\_\_\_\_  
 Signature of Claimant Printed Name Date

**If you should need assistance in the completion of this claim form  
 Please call (877) 274-1958**

**\* \* \* SEND COMPLETED CLAIM FORM TO ABOVE ADDRESS OR FAX TO (781) 770-0492 \* \* \***



**SECTION 4 - ATTENDING PHYSICIAN'S STATEMENT**

**• KIDNEY FAILURE •**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_

**COVERED CONDITIONS ARE LIMITED TO THE FOLLOWING**

**"Renal Failure"** means the chronic, irreversible failure of both of the kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (*at least weekly*); or which results in kidney transplantation. Renal failure is covered, provided it is not cause by a traumatic event, including surgical traumas.

**PLEASE NOTE: The actual policy language and definitions will control.**

1. Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure of both kidneys to function?  
YES  NO
2. Does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis at least weekly or which results in kidney transplantation? YES  NO
3. If yes, what is the date the patient is to begin or has begun dialysis? \_\_\_\_\_
4. What is the cause of the patient's renal failure? \_\_\_\_\_
5. When was the patient first treated for signs or symptoms of this condition? \_\_\_\_\_
6. Was the patient confined on an inpatient basis in a hospital for more than 30 days? YES  NO
7. Were there any other conditions which caused or contributed to the patient's renal failure? YES  NO

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

8. Please provide the names and addresses of other physicians who attended this patient for this or any other related condition.

Name	Address
_____	_____
_____	_____
_____	_____

**ATTENDING PHYSICIAN'S SIGNATURE**

*I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.*

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone # \_\_\_\_\_  
*(Attending Physician) Please Print*

Address \_\_\_\_\_  
*(City, State, Zip Code)*

Signature \_\_\_\_\_ Date \_\_\_\_\_ Fax # \_\_\_\_\_

# 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
- prevent fraud
- or perform other business functions on our behalf
- provide customer service or reinsurance coverage

▶ ***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 Box331 / Athol Springs, NY 14010

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.

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