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

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

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.

- ❑ Cancer/Carcinoma In Situ/Skin Cancer
- ❑ Myocardial Infarction *(Heart Attack)*
- ❑ Coronary Artery Bypass Surgery
- ❑ Alzheimer's Disease
- ❑ Amyotrophic Lateral Sclerosis *(ALS)*
- ❑ Renal Failure *(Kidney Failure)*
- ❑ Major Organ Transplant *(Covered Organs: heart, lung, liver, kidney or pancreas)*
- ❑ 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:

Name	Address	Dates Seen

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:

Name	Address	Dates Seen

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

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

HEALTH SCREENING/GENETIC TESTING INFORMATION

DATE TEST PERFORMED _____

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED?

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

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SECTION 4 – ATTENDING PHYSICIAN'S STATEMENT

• ALZHEIMER'S DISEASE •

Patient's Name: _____ Date of Birth: _____ Policy #: _____

COVERED CONDITIONS ARE LIMITED TO THE FOLLOWING

The term *"Alzheimer's Disease"* means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests *(e.g., CT Scan, MRI, PET of the brain).* This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

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

1. Date the patient was diagnosed with Alzheimer 's disease. _____
   (Attach medical documentation which supports loss of intellectual capacity resulting in impairment of memory and judgment as demonstrated by cognitive testing and supported in the form of an CT Scan, MRI, PET of the Brain).
2. Please check all the Activities of Daily living that the patient is permanently unable to perform.
   Bathing ❑ Continence ❑ Dressing ❑ Eating ❑ Toileting ❑ Transferring ❑
3. What tests have been performed to rule out other dementing organic brain disorders and psychiatric illnesses?
   _____
4. When did the patient first suffer symptoms? _____
5. Please outline the clinical course and briefly describe the patient's signs and symptoms.
   _____
   _____
6. Was the patient confined on an inpatient basis in a hospital for more than 30 days? YES ❑ NO ❑
7. 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
FAMILY MATTERS. NO MATTER WHAT.

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

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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 _____