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.

CATASTROPHIC LOSS RIDER CLAIM KIT

INSTRUCTIONS FOR FILING A CATASTROPHIC LOSS CLAIM

If you have the Catastrophic Loss Rider on your disability insurance coverage, you may be eligible for a monthly benefit if, due to sickness or injury, you are continuously not able to perform two or more Activities of Daily Living without assistance. The Elimination Period and Benefit Amount will appear on your Policy Specification page if you have this Rider. No benefits are payable during the elimination period. Activities of Daily Living as defined in the Rider are Continence, Bathing, Transferring, Dressing, Toileting and Eating.

1. Please complete the Policyholder/Claimant's Information section. *(If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)*

2. 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)*

3. Have your physician complete the Attending Physician's Statement.

If you should need assistance in the completion of the claim form

Please call 877-274-1958

Mail forms to: Life Insurance Company of Boston & New York, PO Box 219 • Canton MA 02021

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POLICYHOLDER/CLAIMANT'S STATEMENT

Full Name of Insured: _____ Policy No: _____

Is Insured Known by any other name? ❑ YES ❑ NO If YES, please advise: _____

Date of Birth: _____ Social Security No. _____ Telephone No. _____

Address: _____
Street or PO Box *Apt. No.* *City/State* *Zip Code*

What is your primary diagnosis? _____

Date of Illness/Accident: _____ Date First Treated: _____

Please provide examples of what Activities of Daily Living you require assistance with:

_____

_____

_____

Are there any other conditions contributing to your need for assistance? ❑ YES ❑ NO

If YES, please explain: _____

_____

Where are you currently residing: ❑ Residence ❑ Hospital ❑ Residential Care Facility

❑ Nursing Care Facility *(Nursing Home)* ❑ Assisted Living Facility ❑ Other _____

Please list all treating Physicians/Hospitals for this injury or illness: Use separate sheet if necessary.

Name of Physician/Hospital	Address	Date(s) treated

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 Insured Date

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ATTENDING PHYSICIAN'S STATEMENT

Note: Insured is Responsible for any cost involved in the completion of this Attending Physician's Statement

Patient Name: _____ Date of Birth: _____

Diagnosis and Concurrent Conditions: _____

Date first treated for this condition: _____ Date Last Treated: _____

Has patient ever had same or similar condition: ❑ YES ❑ NO

If YES, please explain:

_____

_____

Activities of Daily Living – *Please indicate activities of daily living for which the patient requires assistance.*

❑ **Continence:** Maintaining control of bladder and/or functions of the bowel, including the ability to use ostomy supplies or other devices such as catheters.

❑ **Bathing:** Washing in a bathtub, shower, or other accepted manner, including getting in and out of the bathtub or shower.

❑ **Transferring:** Moving between the bed and the chair or the bed and a wheelchair with or without assistive device.

❑ **Dressing:** Putting on and taking off all necessary items of clothing and/or medically necessary braces and artificial limbs usually worn.

❑ **Toileting:** Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

❑ **Eating:** Performing all major tasks of getting food into the body with or without assistive device.

What is your prognosis for recovery? _____

The patient's current level of impairment will remain the same for approximately:

❑ 3-6 months ❑ 6-12 months ❑ 1-2 years ❑ 2+ years

Is the patient mentally competent to understand ordinary business transactions and to receive proceeds of insurance? ❑ YES ❑ NO

After you have completed this form, please attach copies of office notes, test results, hospital admission and discharge summaries and any consulting physician's reports relating to the above medical condition.

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.

Date: _____ Signature: _____

Physician's Full Name: _____ Telephone No: _____

Address: _____

NOTICE OF INFORMATION PRIVACY PRACTICES

Life Insurance Company of Boston & New York
(Herein referred to as "we", "us", "our")

LIFE INSURANCE COMPANY OF BOSTON & NEW YORK
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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

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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 _____