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.

LIFE CLAIM KIT

FOR PROCESSING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS

INSTRUCTIONS FOR FILING A LIFE CLAIM

On behalf of Life Insurance Company of Boston & New York, please accept our sincere condolences for your loss. We realize that this is a difficult time for you and your family and we will make every effort to process your claim promptly.

To expedite the processing of your claim, it is important that you submit all of the necessary information requested below.

1. The claim form should be fully completed by the named beneficiary or their authorized representative and signed where indicated. If more than one named beneficiary, please use the Additional Beneficiary form.
2. A clear copy of the death certificate for the insured.
3. The insurance policy. If the policy cannot be found, please complete the lost policy section of the claim form.
4. If claim is being made for accidental death benefits, the named beneficiary must also complete the Accidental Death Claim form. Applicable police and accident reports should also be attached.
5. If the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms, an authorized representative of the employer must complete the Employer's Statement. All original enrollment forms and beneficiary changes must also be included with the claim.
6. Each beneficiary should complete the Life Insurance Payment Options form.
7. A HIPAA - Compliant authorization form should be completed by the named beneficiary or next of kin if named beneficiary is not next of kin.
8. If proceeds are assigned to a funeral home, we must be provided with the assignment form and the funeral bill if required by state.

*** * * Policies that have been in force less than two years could be contestable * * ***

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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LIFE CLAIM FORM

Policy Numbers of the Company under which claim is made by the undersigned

#1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Full Name of Insured _____ Married ❑ Widowed ❑

Address _____ Single ❑ Divorced ❑

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

Date of Birth _____ Date of Death _____ Soc. Sec. No. _____

Date Last Worked _____ Name of Employer _____

Please complete the following if Policy was in force less than 2 years and include a signed HIPAA-Compliant Authorization for the release of medical records.

Full Names and Addresses of all Physicians and Hospitals where insured was treated in last 5 years

	Name	Address	Telephone No.
1.			
2.			
3.			

BENEFICIARY'S INFORMATION

Beneficiary's Name _____ Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____ Beneficiary's Telephone No. _____

Beneficiary's Address _____

Beneficiary's Mailing Address *(if different)* _____

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 Beneficiary | Printed Name | Date

STATEMENT OF POLICY LOSS *(To be completed only if original policy could not be found after a thorough search)*

Insured _____ Policy No _____

This policy was lost or destroyed. If the policy is found later, I agree to surrender it to the company without claim.

X _____ _____ _____
Signature of Beneficiary | Date | Signature of Witness

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ACCIDENTAL DEATH CLAIM FORM

Beneficiary must fully complete this section if claiming Accidental Death Benefit

Insured's Name: _____

Date and time of accident causing death: Place of Death: Highway ❑ Home ❑ Work ❑

Date: _____ 20____ AM ❑ PM ❑ Recreation ❑ Other ❑ _____

Describe Accident in detail: ***(Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)***

_____

_____

_____

_____

_____

Names of PHYSICIANS and HOSPITALS where Insured received treatment

Name	Address

Was an Autopsy Performed? YES ❑ NO ❑ If YES, by whom, where and date.

Name	Address	Date

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X _____ _____ _____

Signature of Beneficiary | Printed Name | Date

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EMPLOYER'S STATEMENT

This form must be completed by an authorized representative of the Employer if the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms.

LIFE CLAIM

Name of Insured: _____ Group Policy No: _____ Div. _____

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

Address of Insured: _____ Certificate No: _____

Date Insured Last Worked: _____ Date of Death: _____ Amount of Insurance: _____

No. of Hours worked each week: _____ Annual Earnings as of date last worked: _____

Reason for leaving work: Disability ❑ Resignation ❑ Vacation ❑ Leave of Absence ❑ Retired ❑
Lay Off ❑ Dismissed ❑ Other ❑ *(Specify)* _____

Was Insured an Employee at time of death? YES ❑ NO ❑ Insured's Occupation: _____

Date Employed: _____ Date of Birth: _____ Effective Date of Insurance: _____

Was Insurance terminated prior to death? YES ❑ NO ❑ If YES, date of termination and reason: _____

DEPENDENT LIFE CLAIM

Name of Dependent: _____ Date of Birth: _____ Date of Death: _____

Address of Dependent: _____
Street City/Town State Zip

Was Insurance terminated prior to death? YES ❑ NO ❑ If YES, date of termination and reason: _____

I hereby certify that the date through which premium for this Insured has been paid is: _____
Month/Day/Year

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 Authorized Representative Street City/Town State Zip

_____ _____
Employer Area Code Telephone Ext.

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ADDITIONAL BENEFICIARY STATEMENT

(To be completed if there is more than one beneficiary)

Name of Insured: _____ **Policy #:** _____

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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 Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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 Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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 Beneficiary | Printed Name | Date

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LIFE INSURANCE COMPANY OF BOSTON&NEW YORK
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LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options and select your option by checking the appropriate box and signing this form. Payment options may vary based on the policy selected. Please consult the policy for available options. If you have any questions or would like to discuss other payment options, please call our Claim Services team at 1-877-274-1958. Please return this form with your claim.

❑ **Lump sum payment.** By choosing this option, you are electing to receive the proceeds due in one lump sum payment. *(This is the most common payment option)*

❑ **Sum Payable as monthly income for a fixed number of years.** By choosing this option, you are electing to leave the Sum Payable with Life Insurance Company of Boston & New York. You will receive a monthly income for up to 20 years. We will pay an income once a month for the number of years chosen and the first payment will begin one month after the payment option date. Please circle the number of years you wish to receive this monthly income. The monthly income will be the payment amount for each $1,000 of sum payable next to the number of years chosen. We will pay interest on the amount left with us at a rate of at least 2 ½% per year.

MONTHLY PAYMENT FOR EACH $1,000 OF SUM PAYABLE

YEARS	PAYMENT	YEARS	PAYMENT
1	84.28	11	8.64
2	42.66	12	8.02
3	28.79	13	7.49
4	21.86	14	7.03
5	17.70	15	6.64
6	14.93	16	6.30
7	12.95	17	6.00
8	11.47	18	5.73
9	10.32	19	5.49
10	9.39	20	5.27

❑ **Interest Income.** By choosing this option, you are electing to leave the Sum Payable with Life Insurance Company of Boston & New York. We will pay interest on the amount left on deposit at a rate of at least 2 ½ % per year. The interest will be paid once a year and the first payment will be issued one year after the Payment Option Date. You may choose the number of years, up to 15 years, to receive the interest income. The payee may withdraw all or a part of the Sum Payable at any time, but may not withdraw any amount if less than $1,000 will be left with us. In this case, the payee must withdraw the full amount. Please advise the number of years _____.

❑ **Sum Payable as monthly income of a fixed amount.** By choosing this option, you are electing to leave the Sum Payable with Life Insurance Company of Boston & New York and choosing, subject to our consent, an amount of monthly income that you will receive. Monthly payments must be at least $5.00 for each $1000 of Sum Payable. The first payment will begin as of the payment option date. We will credit interest on the balance of the Sum Payable left with us. This interest will be a rate of at least 2 ½% a year, compounded once a year. Payment will last until the Sum Payable, plus interest runs out.

Date	**X** Signature of Beneficiary
Printed Name	Insured's Name

*** Interest earned on the Sum Payable left with Life Insurance Company of Boston & New York may be taxable. Please consult your tax advisor ***

NOTICE OF INFORMATION PRIVACY PRACTICES

LIFE INSURANCE COMPANY OF BOSTON & NEW YORK
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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 _____