



HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS:

- The Administrator will complete the Policyholder Statement section. You should complete all remaining sections and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- Please make sure that you sign the Authorization for Release of Information on the reverse side of this claim form.
- Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:
New York Life Insurance Company
 SPE Insurance Program
 P. O. BOX 9159
 Phoenix, AZ 85068-9159
 (800) 337-3140

CLAIM PROCESSING INFORMATION (COMPLETED BY MEMBER)

MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME TELEPHONE NUMBER: () _____

DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS?
 YES NO
 IF YES, PROVIDE INFORMATION REQUESTED BELOW:
 OTHER CARRIER'S NAME: _____
 ADDRESS: _____
 TELEPHONE NUMBER: _____
 NAME OF COVERED PERSON: _____
 PLAN NUMBER: _____

ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
 MONTH ___ DAY ___ YEAR ___

SOCIAL SECURITY NUMBER _____ GROUP POLICY NUMBER: G-29467

NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT:

NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

DATES OF HOSPITAL CONFINEMENT:
 FROM _____ TO _____
 FROM _____ TO _____
 FROM _____ TO _____

NATURE OF SICKNESS OR INJURY:

ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
 MONTH ___ DAY ___ YEAR ___

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

STREET ADDRESS: (IF DIFFERENT FROM MEMBER'S ADDRESS) _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT'S RELATIONSHIP TO MEMBER:
 SPOUSE CHILD STEPCHILD OTHER _____

PATIENT SEX: MALE FEMALE

DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___

SOCIAL SECURITY NUMBER _____

IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:
 MARRIED? YES NO IN THE MILITARY? YES NO
 EMPLOYED? YES NO FEDERAL EMPLOYEE? YES NO

MEMBER CERTIFICATION

I CERTIFY: I HAVE READ AND UNDERSTAND THE FRAUD STATEMENT THAT IS APPLICABLE TO THE STATE IN WHICH I RESIDE. ANY PERSON WHO KNOWINGLY AND WITH THE 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

New York Residents: Any person who knowingly and with the 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 INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE: _____ DATE: _____
 (SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

POLICYHOLDER STATEMENT (COMPLETED BY ADMINISTRATOR)

MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

SEX: MALE FEMALE DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___

MEMBER'S INSURANCE EFFECTIVE DATE: MONTH ___ DAY ___ YEAR ___

MEMBER'S PAID TO DATE: MONTH ___ DAY ___ YEAR ___

CERTIFICATE HOLDER ID: _____

NAME OF POLICYHOLDER: _____

EMPLOYMENT STATUS: ACTIVELY AT WORK RETIRED

AMOUNT OF DAILY BENEFIT: \$ _____

DOES THIS MEMBER HAVE DEPENDENT'S INSURANCE? YES NO
 IF YES, SPOUSE CHILDREN

DEPENDENT'S INSURANCE EFFECTIVE DATE (IF APPLICABLE):
 MO ___ DY ___ YR ___

DEPENDENT'S PAID TO DATE: MO ___ DY ___ YR ___

AMOUNT OF DAILY BENEFIT (DEPENDENT): \$ _____

I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

DATE SIGNED: _____ BY: _____ (AUTHORIZED REPRESENTATIVE) _____ (TITLE)

AUTHORIZATION FOR RELEASE OF INFORMATION (COMPLETED BY PATIENT)

TO: All providers of medical services and supplies, pharmacy related service organizations, prescription history database suppliers, employers, insurance institution, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals, pharmacy related service organizations and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

PATIENT'S SIGNATURE (PARENT'S/GUARDIAN IF MINOR)

DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT:

MO DY YR

ILLNESS (FIRST SYMPTOM) OR

INJURY (ACCIDENT) OR

PREGNANCY (LMP)

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

1. _____

2. _____

3. _____

4. _____

DATE FIRST CONSULTED YOU FOR THIS CONDITION:

MO DY YR

_____/_____/_____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

IF YES, GIVE FIRST DATE: MO DY YR

_____/_____/_____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:

MO DY YR MO DY YR

FROM ____/____/_____ THROUGH ____/____/_____

IS CONDITION DUE TO PREGNANCY? YES NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.

MO DY YR

_____/_____/_____

NAME OF REFERRING PHYSICIAN

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP & PHONE #

FEDERAL TAX I.D. NUMBER

SSN

EIN

SIGNATURE _____

DATE _____

PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.