DISABILITY INCOME CLAIM INSTRUCTIONS

(PLEASE KEEP THIS NOTICE FOR FUTURE REFERENCE)

Please answer all questions on the Member's Statement of your Disability Income/Office Overhead Claim form and sign and date the bottom of Page 3 where indicated. Also date and sign the Authorization for Release of Information on Page 5 and have your Medical Provider complete the rest of the form. Please see that the completed form is returned to:

GEBA
PO Box 206
Annapolis Junction, MD 20701

Telephone #: (800) 826-1126

If you recover or return to work, please notify New York Life immediately by completing and mailing the statement below to: above

New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

If you have any questions concerning your claim, you may call the New York Life Insurance Company's Disability Claims Unit at (800) 695-4226, Menu 1.

STATEMENT OF RECOVERY OR RETURN TO WORK

(PLEASE COMPLETE FULLY AND DETACH BEFORE MAILING)

Name: _____

Address: _____

_____

Social Security No.: _____-_____-_____ Policy **G-29344 – 0**

I recovered: ☐ Returned to work ☐ on _____/_____/_____
Mo. Day Year

Other: _____

_____

_____

Date: _____ Signature: _____

Telephone No.: ( ) _____ _____
Print Name

GEBA DISABILITY INCOME CLAIM FORM

Social Security Number

Male
Female

Height:

Date of Birth

Weight

Name

Email Address

Address

City

State

Zip Code

Home Number

Work Number

Cell Number

Employer's Name

Address

City

State

Zip Code

Date Last Worked

Normal Number of Hours Worked Per Week

What is the nature of your disability?

Is this disability due to an Injury? Yes

If "Yes", when?

Type of Injury:

Date first treated for this disability:

Date first unable to work:

Have you attempted to return to your occupation since the date of disability began? If so, give details:

If returned to work or recovered, please give date:

If you have returned to work part-time, give no. hours per day:

Days per week:

If you have not yet returned to work, when do you expect to?

NAMES AND ADDRESSES OF FIRST PROVIDER CONSULTED AND OTHER PROVIDERS SEEN INCLUDING YOUR PRESENT ATTENDING PROVIDER.

Name:

Address:

Telephone No.: Fax Number:

Treated From: Treated From:

Name:

Address:

Telephone No.: Fax Number:

Treated From: Treated From:

Name:

Address:

Telephone No.: Fax Number:

Treated From: Treated From:

Name:

Address:

Telephone No.: Fax Number:

Treated From: Treated From:

Your Occupation:

Please fully describe the duties of your occupation at the time the claimant stopped working, including the percentage of time at each activity.

What are your daily activities at this time?

Are you receiving or will you be entitled to receive benefits from any of the following:

Salary Continuance?	◯ Yes	◯ No	Salary or other Compensation?	◯ Yes	◯ No
State Disability Benefits?	◯ Yes	◯ No	Workers' Compensation?	◯ Yes	◯ No
Social Security Law?	◯ Yes	◯ No	Another Group Insurance Plan?	◯ Yes	◯ No
Pension Plan?	◯ Yes	◯ No	No Fault Benefits?	◯ Yes	◯ No
Individual Disability Income Policy?	◯ Yes	◯ No			

If any of the above was answered "Yes", please complete the information requested below:

Policy Number	Claim Number	Name and Address of Payer	Amount of Payment

Declare that the answers on Pages 1, 2 and 3 of this form are complete and true to the best of my knowledge. Furthermore, I agree that I will advise New York Life Insurance Company of my return to any type of work and I will return payments to which I am not entitled to by reason of my return to work or termination of my Covered Disability.

New York Residents: 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: _____/_____/_____ Member's Signature: _____
MO DAY YEAR

The Member or someone on his/her behalf must Sign here and on the Authorization For Release Of Information

New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

Authorization for Release Of Information

TO: All providers of medical services and supplies, pharmacy related service organizations, employers, insurance institutions, 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 related to mental illness and/or AIDS/ARC/HIV) and prescription records. This information will be used to evaluate claims for benefits.

In Oklahoma, the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

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 New York Life 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 Date

_____
Print Name

Social Security No.: _____-_____-_____

Revision GEBA 2/2018

MEDICAL PROVIDER'S STATEMENT

(The patient is responsible for the completion of this form without expense to the Company)

Notice to Provider: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME: _____ DATE OF BIRTH: _____/_____/_____
(First) (Middle) (Last) *MM DD YYYY*

2. CURRENT MEDICAL CONDITION(s):

PRIMARY DIAGNOSIS: _____ ICD-9 CM CODE: _____

SECONDARY DIAGNOSIS:_____ ICD-9 CM CODE: _____

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: _____/_____/_____
(*Month) (Day) (Year)*

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: _____/_____/_____
(*Month) (Day) (Year)*

DATE THAT PATIENT LAST CONSULTED YOU FOR THIS CONDITION: _____/_____/_____
(*Month) (Day) (Year)*

5. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES ☐ NO ☐
(If "Yes", please provide the name and address of that practitioner):_____

_____

6. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR INJURY OR SICKNESS? YES ☐ NO ☐
(If "Yes", please provide details and dates of prior treatment): _____

_____

7. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES ☐ NO ☐
(If "Yes", provide diagnosis(es) and dates of prior treatment): _____

_____

8. OBJECTIVE FINDINGS ***(Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDC)***: _____

9. HAS PATIENT BEEN HOSPITALIZED? YES ☐ NO ☐ ***(If "YES", provide reason, hospital name and dates of confinement):***_____

_____

10. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: ***(Include surgery and medications prescribed if applicable***

_____

_____

_____

Continued on next page

MEDICAL PROVIDER'S STATEMENT
(Continued From Previous Page)

11. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? YES☐ NO☐ ***(If "Yes", please provide the name and address of all applicable physicians or practitioners)***: _____

_____

12. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? YES☐ NO☐
IF "NO", WHEN DO YOU EXPECT THAT THE
PATIENT WILL BE ABLE TO PERFORM SOME WORK? _____/_____/_____
(MO) (DAY) (YEAR)

13. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES☐ NO ☐ ***(If "Yes", please describe)***_____

_____

14. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

a) THE PATIENT WAS UNABLE TO WORK FROM: _____/_____/_____ THROUGH: _____/_____/_____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

b) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: _____/_____/_____ THROUGH : _____/_____/_____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

15. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO HIS OR HER MEDICAL CONDITION ***(If none, indicate "NONE):*** _____

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16. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES☐ NO ☐

IF "YES" DATE RELEASED FROM YOUR CARE:

_____/_____/_____
(MO) (DAY) (YEAR)

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION:

_____/_____/_____
(MO) (DAY) (YEAR)

MEDICAL PROVIDER'S DECLARATION AND SIGNATURE

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

_____ _____ ( ) _____
PROVIDER'S NAME (PLEASE PRINT) SPECIALTY TELEPHONE NUMBER

_____ _____ _____ _____
STREET ADDRESS CITY STATE ZIPCODE

_____ _____
PROVIDER'S SIGNATURE DATE SIGNED

GEBA

IMPORTANT NOTICE

FOR ALASKA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR ARIZONA RESIDENTS
"For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR CALIFORNIA RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

FOR COLORADO RESIDENTS
"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a claimant for the purpose of defrauding or attempting to defraud the claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

FOR DELWARE RESIDENTS
"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR DISTRICT OF COLUMBIA RESIDENTS
"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FOR FLORIDA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS
"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS
"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR INDIANA RESIDENTS
"A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony."

FOR KENTUCKY RESIDENTS
"Any person who knowingly, and with intent to defraud any insurance company or other person files a 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."

FOR LOUISIANA RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR MAINE RESIDENTS

"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits."

FOR MARYLAND RESIDENTS

"Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR MINNESOTSA RESIDENTS
"Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

FOR NEW HAMPSHIRE RESIDENTS
"Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

FOR NEW JERSEY RESIDENTS
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties in New Jersey."

FOR NEW MEXICO RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil crimes and criminal penalties."

FOR OHIO RESIDENTS
"Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of Insurance Fraud."

FOR OKLAHOMA RESIDENTS
WARNING: "Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony."

FOR OREGON RESIDENTS
"Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals, for purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud."

FOR PENNSYLVANIA RESIDENTS
"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 subjects such person to criminal and civil penalties."

FOR TENNESSEE RESIDENTS
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

FOR TEXAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

FOR VERMONT RESIDENTS
"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."

FOR VIRGINIA RESIDENTS:
"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits."