Group/Association - Proof of Loss
Life Insurance Accidental Death Insurance

MAIL TO: New York Life Group Benefit Solutions
P.O. Box 22328
Pittsburgh, PA 15222-0328
E-mail: claims.pghlif2@newyorklife.com
Fax: 877-300-6770

CLEAR FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Connecticut General Life Insurance Company
Life Insurance Company of North America
New York Life Group Insurance Company of NY

NEW YORK FRAUD WARNING: 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 $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***Arizona, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR LIFE INSURANCE OR ACCIDENTAL DEATH PROCEEDS ONLY. COMPLETE THE FORM ACCORDING TO THE INSTRUCTIONS, TO AVOID DELAY OR RETURN OF THE FORM. **IN BOXES WHICH CONTAIN THE SYMBOL ⓘ , ADDITIONAL INFORMATION IS PROVIDED WHEN HOVERING OVER THE FIELD TO BE COMPLETED. THIS FEATURE IS ONLY AVAILABLE ON THE FILLABLE VERSION OF THIS FORM.**

To The Employer/Administrator:

1. **If claiming employee death benefits, please complete Sections A and C. If claiming dependent spouse or child benefits, please complete Sections A, B, and C.**
2. **If claiming voluntary or employee-paid benefits, please provide all of the enrollment history for the employee and the dependent (if claiming dependent benefits).**
3. **Please have each beneficiary review pages 1 through 7 and complete the appropriate pages.**
4. **Submit completed form to your assigned Claim Office with a Death Certificate, Beneficiary Designation and Enrollment Information, if applicable.**

SECTION A: EMPLOYEE INFORMATION

ⓘ Name of Employee/Member *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security Number | Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Employee's/Member's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Policy Number(s): List all policies under which benefits are due. | Occupation | ⓘ Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

ⓘ Check all of the boxes that apply to the Employee/Member's employment/membership status and job classification. Hours per week _____
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local Number _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

ⓘ Basic Annual Earnings | ⓘ Effective Date of Earnings | ⓘ Employee's Division/Location | ⓘ Policy Class Number

ⓘ Amount of Insurance: **If claiming voluntary benefits, please provide enrollment information.**

Life Basic: Voluntary: SIB:

AD&D (Please complete only if claiming AD&D benefits) : Basic: Voluntary: BTA:

ⓘ Has voluntary coverage for the employee/dependent been in effect continuously since enrollment? ☐ Yes ☐ No
If No, please include enrollment history and enrollment forms if not already provided.

ⓘ Date Hired/Member of Assoc. | ⓘ Effective Date of Insurance | ⓘ Date Last Worked | Date of Death | ⓘ Premium Paid Through Date | ⓘ Has an assignment been taken? *(If yes, attach copy)* ☐ Yes ☐ No

Was the above Considered an Employee/Association Member until his/her Date of Death? ☐ Yes ☐ No *If No, Please Explain*

ⓘ Was the Employee actively at work until the date of the Dependent's death? ☐ Yes ☐ No *If No, indicate reason below.*

ⓘ If the Employee was not actively at work immediately prior to his/her death or Dependent's death, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Minnesota Continuation *(Please attach COBRA form.)*
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged ☐ Other: _____

Was coverage still in effect through the Date of Death? *If No, Please Explain* ☐ Yes ☐ No

ⓘ Is there a Beneficiary Designation on file for this Employee/Member? ☐ Yes ☐ No
Please provide the most recent beneficiary designation with the claim.

Please provide the Name of your Medical Insurance Carrier

Beneficiary: please review and keep for your records.

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LMS-613500 Rev. 04/2023

SECTION B: DEPENDENT SPOUSE OR DEPENDENT CHILD INFORMATION

Name of Dependent *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security Number	Sex ☐ M ☐ F

Relationship to Employee/Association Member	Amount of Dependent Insurance	Dependent's Occupation
	Life Basic: _____ Voluntary: _____ **AD&D** Basic: _____ Voluntary: _____	

Was the Dependent Totally Disabled? ☐ Yes ☐ No	If yes, Date Disability Began	Dependent's Last Day Worked	Date of Marriage	Date of Death

Dependent's Employer	Dependent's Employer's Telephone Number	Is Child ☐ Full-time student ☐ Part-time student	Date Last Attended School

Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)*	School Telephone Number

SECTION C: EMPLOYER'S/ADMINISTRATOR'S CERTIFICATION

Name of Employer/Association	Email Address

Address *(Street)* *City* *(State)* *(Zip)*	Telephone Number

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature	Title	Date

SECTION D: ACCIDENTAL DEATH INFORMATION

ⓘ Where and How Did the Accident Happen? Please Describe in Detail	Date and Time of Accident

SECTION E: BENEFICIARY INFORMATION

ⓘ Name of Beneficiary *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security Number	Sex ☐ M ☐ F

Mailing Address *(Street)* *(City)* *(State)* *(Zip Code)*	Relationship to Deceased	Daytime Telephone Number

Email Address

Name and Address of Legal Guardian if Beneficiary is A Minor *If guardianship of the minor's estate has been established, please attach court order.*

Did the Deceased convert or port his/her life insurance coverage prior to his/her death? ☐ Yes ☐ No

If claiming voluntary life or basic and/or voluntary AD&D benefits, please list all hospital, clinics or physicians that treated the deceased within the past 5 years.

Name	**Phone Number**	**Complete Address**	**Treatment Period**

I certify that the foregoing information is true, correct and complete to the best of my knowledge.

Beneficiary Signature _____ Date _____

New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance

If your insurance benefit is $5,000 or more, NYL GBS will automatically open a free, interest-bearing account in your name. This account, called the NYL GBS Survivor Assurance, is a convenient and secure place to keep your proceeds while you decide how to best use them. Please review the attached NYL GBS Survivor Assurance Disclosure Notice for full details about the account.* Account balances are the liability of the insurance company and are not insured by the Federal Deposit Insurance Corporation or any federal agency. The insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, NYL GBS will send you a check for the total benefit amount.

*Please read the NYL GBS Survivor Assurance Disclosure Notice before signing below.

I understand that if my benefit is $5,000 or more, I will receive a NYL GBS Survivor Assurance account.

I understand that I may write a draft for the total amount in my account at any time.

I understand that the account balance may be reduced for any benefit payment by the insurance company made in error

I acknowledge that, if I do not separately sign the NYL GBS Survivor Assurance Section of this Claim Form, I am not participating in the NYL GBS Survivor Assurance and that I will receive a single lump sum check for the proceeds due if my claim is approved.

Signature* _____ Date _____

*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

Beneficiary: Please complete and return to the Employer or New York Life Group Benefit Solutions.

Disclosure Authorization

GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

Deceased's Name: _____ **Deceased's Date of Birth:** _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning the deceased's health condition, or health history, or regarding any advice, care or treatment provided to the deceased. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice of the deceased's physical or mental condition, or other information concerning the deceased which may be needed to determine policy claim benefits with respect to the deceased. This may also include (but is not limited to) information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. I understand that I may choose whether to receive the results of any laboratory tests or medical examinations performed. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Insured's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the deceased to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning the deceased's occupation, activities, employee/ employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used by the Company to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the deceased. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be released to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If the medical information contains information regarding drug or alcohol abuse, I understand that the deceased's records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

I hereby represent that I am authorized to execute this Disclosure Authorization for the release of this information.

Signature of Claimant or Claimant's Authorized Representative: _____ **Date:** _____

Relationship, if other than Claimant: _____ Claimant's Date of Birth: _____

"Company" refers to: Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

CLICK TO SUBMIT

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ELECTRONIC COMMUNICATIONS DISCLOSURE AND CONSENT

Please read this information carefully. Then, print and keep a copy for yourself.

As a valued New York Life Group Benefit Solutions (NYL GBS) customer, we send you information about your benefits through the mail. This information may include:

- Claim forms, authorizations, disclosures, affidavits, electronic funds transfer agreements, privacy notices, and letters letting you know about changes to any of these items
- Claim status updates letting you know that we've received a claim, or that we've updated the status of a claim
- Letters asking you, or someone else, for additional information to help with the review of a claim.

Did you know that you may also give us consent to send you this information electronically?
NYL GBS has an easy to use secure email encryption tool that allows us to communicate with you electronically. All you need is a computer, internet access, and a personal email address (called a Designated Email).

By giving us your consent, you understand you may no longer receive information in paper form and you accept responsibility for promptly reviewing the secure emails you receive. This ensures you can take appropriate action so that any benefits you are eligible for are not delayed or that any rights you have are not affected. If downloading communications from a secure portal, delivery of information sent to you is deemed complete once all of data comprising the information has been uploaded to our secure web portal. If receiving communications by secure email, delivery of information sent to you is deemed complete once all data comprising the information has been received by the email server of the system used to provide your Designated Email.

What do I need to know before I give my consent?

Access to Paper Copies

At any time, you can still request paper copies of information. Simply email us from your valid Designated Email, call or send us a letter by mail to: **New York Life Group Benefit Solutions, P.O. Box 22328, Pittsburgh, PA 15222-0328**

We keep copies of the information we email for the time periods required by law. We recommend saving or printing copies of the information you get electronically to ensure you have it when you need it.

System Requirements

To use the NYL GBS secure email tool, access messages, and keep copies of the information we send, you must have a working, personal Designated Email address and a computing or communications device with:

- Working Internet access
- Web browser that supports 128-bit encryption (such as Chrome®, Firefox®, Microsoft Edge® , or Safari®),
- 16 MB of available memory (32 MB of RAM recommended) and
- Program that can view, save and print PDF files (such as Adobe® Reader® 4.0 or higher).

Our Right to Send Paper

We have the right to send you information through the mail even if you agreed to receive it electronically. For example, we may send you a letter through the mail if we have a system outage, if we suspect fraud, if for any reason your Designated Email does not accept emails from us, or if we receive notification that you have not opened your email messages.

Modification of Consent Terms

We reserve the right to modify (change) these terms and conditions if we choose. We will provide you with notice of a modification electronically, and the date it is to go into effect. If you do not agree to the new terms and conditions in the notice, you may provide your Withdrawal of Consent before the effective date. Failure to withdraw your consent, or follow the instructions in the notice, lets us know that you agree to the new terms.

Please review and keep for your records.

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Withdrawal of Consent

Your consent remains in effect until you tell us otherwise and provide a Withdrawal of Consent. You may withdraw your consent at any time if you decide you want to go back to paper information. To contact us, you may email using the same valid, personal e-mail address you used to register for secure emails, call, or send us a letter by mail (See office address above).

Withdrawing your consent will let us know that you want to stop receiving secure emails. It will not change the outcome of any information we have already sent you.

Your Consent

Please read the following paragraph, make your selection, print and sign your name, enter the date, give us your email address.

By signing my name below, I agree that I have read the information about the NYL GBS secure email tool and I wish to receive information electronically from NYL GBS. I also agree that:

1. I have technology that meets the System Requirements highlighted above.
2. I have received written instruction on how to receive and manage messages using the email tool.
3. I will provide and maintain a valid Designated Email and verify that this email belongs to me. I agree to notify GBS of any changes to my Designated Email, including the email address itself, by calling or sending a letter through the mail. (See office information listed above).
4. I understand that NYL GBS may only send me information electronically from this point forward unless I withdraw my consent.
5. I understand that the date my signature is affixed below is the effective date of my consent.

If NYL GBS does not receive your signed Consent, NYL GBS will continue to send paper communications. If you do not wish to receive information electronically from NYL GBS, do not sign or return this form to NYL GBS.

Select One:

☐ I consent to receive information electronically for ALL claims for which I may be eligible for benefits.

Name: _____ **Email Address:** _____

(Please print clearly) *(Please print clearly)*

Signature: _____ **Date:** _____

Employee Name: _____ **Employee Date of Birth:** _____

Please review and keep for your records.

New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance Disclosure Notice

NYL GBS Survivor Assurance Disclosure

If your insurance benefit is $5,000 or more, NYL GBS will establish a free, interest-bearing draft account in your name. This account is a convenient and secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts (checks) will be mailed to you, once your claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. There are charges for the following special services: drafts returned unpaid ($10), stop payment ($12) and copy of draft or statement ($2).

You will receive a quarterly statement for your NYL GBS Survivor Assurance account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. You may also check your account balance online at any time at www.nylgbssurvivorassurance.com.

Drafts are cleared through a draft account at BNY Mellon Bank (contact information on next page). NYL GBS's obligation to pay is satisfied by depositing the total proceeds in the retained asset account. Drafts draw upon funds held by NYL GBS (whereas a "check" draws upon funds held by a banking institution). You may write an unlimited number of drafts, in any amount, at any time up to your account balance. If you wish to withdraw the proceeds in full, you can write a draft for the total amount of the account at any time. You also have the right to receive an initial lump-sum payment in the form of a bank check. Please note that NYL GBS reserves the right to reduce account balances for any payment made in error. You also have the right to name a beneficiary to your account. If an account becomes inactive (as defined by your State's Department of Insurance), NYL GBS will return any remaining balance held in a RAA to your State of residence if no named beneficiary can be located.

This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guarantee association. Please contact the National Organization of Life and Health Insurance website (www.nolhga.com) to learn more about the coverage limitations to the account under a state guaranty association.

All funds are held by the insurance company, or one of its affiliates, which, like a bank, may earn money on the invested amounts that exceed the interest credited to the account and the cost of the additional benefits and services described below. For beneficiaries under policies issued by Connecticut General Life Insurance Company (CGLIC) and Life Insurance Company of North America (LINA), the custodian of the account funds will be CGLIC. For beneficiaries under policies issued by New York Life Group Insurance Company of NY (NYLGICNY), the custodian of the accounts funds will be NYLGICNY.

Disclosure on Interest Earned

You earn an attractive interest rate on the funds in your NYL GBS Survivor Assurance Account from the day it is established until the date it is closed. The NYL GBS Survivor Assurance interest rate is reviewed weekly and will be based upon the previous week's Bank Rate Monitor Index (BRM) or any successor money market index. The BRM Index is the average annual effective yield earned on the money market accounts offered by 100 large US Bank and Thrifts across the country. Any amount that remains in the account will continue to earn interest at a rate equal to the national average bank money market rate.

Please call our toll-free number 855.836.0697 for the current rate. Both your principal and any interest you earn are guaranteed by the insurance company. Any interest earned on the account may be taxable and you should consult a tax, investment, or other financial advisor regarding tax liability and investment options. Interest earned on your account is compounded daily and is credited to your account at the end of each month. All funds, including earned interest, are fully guaranteed by the insurance company.

If you have additional questions or would like additional information about the NYL GBS Survivor Assurance, you can **call us at 800.570.3778**

Or write us at: NYL GBS Survivor Assurance
PO Box 534029
Pittsburgh, PA 15253-4029

For further information, please contact your State Department of Insurance using the information provided on the next page.

Draft Accounts are setup by BNY Mellon Bank, located at 500 Ross Street, Pittsburgh, PA 15262.

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

NYL GBS Survivor Assurance Disclosure Notice

State Insurance Department Contact Information

Alabama
PO Box 303351
Montgomery, AL 36130
(334) 269-3550
www.aldoi.gov

Alaska
PO Box 110805
Juneau, AK 99811
(907) 465-2515
https://www.commerce.alaska.gov/web/ins/

Arizona
100 N. 15th Ave, Suite 261
Phoenix, AZ 85007-2630
(602) 364-3100
https://insurance.az.gov

Arkansas
1 Commerce Way, Bldg 4, Suite 502
Little Rock, AR 72202
(800) 282-9134
www.insurance.arkansas.gov

California
300 South Spring Street, 14th Floor
South Tower
Los Angeles, CA 90013
(800) 927-4357
www.insurance.ca.gov

Colorado
1560 Broadway, Suite 850
Denver, CO 80202
(800) 930-3745
https://doi.colorado.gov/

Connecticut
153 Market Street, 7th Floor
Hartford, CT 06103
(800) 203-3447
www.ct.gov/cid/site/default.asp

Delaware
Delaware Dept of Insurance
1351 W. North Street, Suite 101
Dover, DE 19004
(800) 282-8611
http://insurance.delaware.gov

District of Columbia
1050 First Street, NE, Suite 801
Washington, DC 20002
(202) 727-8000
http://disb.dc.gov

Florida
The Edwin A. Larson Building
200 East Gaines Street, RM 1001A
Tallahassee, FL 32399
(877) 693-5236
www.floir.com

Georgia
Office of Insurance and
Safety Fire Commissioner
Two Martin Luther King, Jr. Drive
West Tower, Suite 704, Floyd Bldg.
Atlanta, Georgia 30334
(800) 656-2298
https://oci.georgia.gov

Hawaii
PO Box 3614
Honolulu, HI 96811
(808) 586-2790
https://cca.hawaii.gov/ins/

Idaho
700 West State Street
PO Box 83720
Boise, ID 83720
(208) 334-4250
www.doi.idaho.gov

Illinois
122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
(312) 814-2420
https://insurance.illinois.gov/

Indiana
311 W Washington Street
STE 103
Indianapolis, IN 46204
(317) 232-2385
https://www.in.gov/idoi

Iowa
1963 Bell Avenue, Suite 100
Des Moines, Iowa 50315
(515) 654-6600
www.iid.state.ia.us

Kansas
1300 SW Arrowhead Road
Topeka, Kansas 66604
(800) 432-2484
https://insurance.kansas.gov

Kentucky
500 Mero Street, 2 SE11
Frankfort, KY 40601
(800) 595-6053
https://insurance.ky.gov/

Louisiana
PO Box 94214
Baton Rouge, Louisiana 70802
(800) 259-5300
https://ldi.la.gov

Maine
34 State House Station
Augusta, ME 04333
(800) 300-5000
https://www.maine.gov/pfr/insurance/home

Maryland
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
(800) 492-6116
http://insurance.maryland.gov

Massachusetts
1000 Washington Street, Suite 810
Boston, MA 02118
(877) 563-4467
https://www.mass.gov

Michigan
PO Box 30220
Lansing, MI 48909
(877) 999-6442
www.michigan.gov/ofir

Minnesota
85 7th Place East, Suite 280
Saint Paul, MN 55101
(651) 539-1500
https://mn.gov/commerce

Mississippi
PO Box 79
Jackson, MS 39205
(800) 562-2957
www.mid.state.ms.us

Missouri
PO Box 690
Jefferson City, MO 65102
(800) 726-7390
www.insurance.mo.gov

Montana
840 Helena Ave.
Helena, MT 59601
(800) 332-6148
https://csimt.gov

Nebraska
PO Box 95087
Lincoln, NE 68509
(877) 564-7323
www.doi.nebraska.gov

Nevada
1818 E. College Pkwy., Suite 103
Carson City, NV 89706
(888) 872-3234
https://doi.nv.gov

New Hampshire
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance

New Jersey
20 West State Street
PO Box 325
Trenton, NJ 08625
(800) 446-7467
www.state.nj.us/dobi/index.html

New Mexico
1120 Paseo De Peralta
Santa Fe, New Mexico 87501
(855) 427-5674
www.osi.state.nm.us

New York
One State Street
New York, NY 10004
(800) 342-3736
www.dfs.ny.gov

North Carolina
1201 Mail Service Center
Raleigh, NC 27699
(855) 408-1212
www.ncdoi.gov

North Dakota
600 E. Boulevard Ave., 5th Floor
Bismarck, ND 58505
(701) 328-2440
https://www.insurance.nd.gov

Ohio
50 W. Town Street, Suite 300
Columbus, OH 43215
(800) 686-1526
www.insurance.ohio.gov

Oklahoma
400 NE 50th Street
Oklahoma City, Oklahoma 73105-1816
(800) 522-0071
https://www.oid.ok.gov

Oregon
PO Box 14480
Salem, OR 97309
(888) 877-4894
http://dfr.oregon.gov

Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120
(877) 881-6388
www.insurance.pa.gov

Puerto Rico
361 Calle Calaf
PO Box 195415
San Juan, Puerto Rico 00919
(787) 304-8686
English: https://ocs.pr.gov/English
Spanish: https://ocs.pr.gov

Rhode Island
1511 Pontiac Avenue, Building 69-2
Cranston, RI 02920
(401) 462-9500
https://www.dbr.ri.gov/divisions/insurance

South Carolina
PO Box 100105
Columbia, SC 29202
(803) 737-6180
www.doi.sc.gov

South Dakota
124 South Euclid Avenue,
2nd Floor
Pierre, SD 57501
(605) 773-3563
https://dlr.sd.gov/insurance

Tennessee
500 James Robertson Pkwy.
Nashville, TN 37243
(800) 342-4029
www.tn.gov/commerce/insurance

Texas
PO Box 12030
Austin, TX 78711-2030
(800) 578-4677
www.tdi.texas.gov

Utah
4315 S. 2700 W., Suite 2300
Taylorsville, Utah 84129
(800) 439-3805
www.insurance.utah.gov

Vermont
89 Main Street
Montpelier, VT 05620-3101
(833) 337-4685
https://dfr.vermont.gov

Virginia
Bureau of Insurance - SCC
PO Box 1157
Richmond, VA 23218
(800) 552-7945
www.scc.virginia.gov/boi

Virgin Islands
For St. Croix
1131 King Street, 3rd Floor, Suite 101
Christiansted, St. Croix, VI 00820
(340) 773-6449
https://ltg.gov.vi

For St. Thomas/St. John
5049 Kongens Gade
St. Thomas, Virgin Islands 00802
(340) 774-2991
https://ltg.gov.vi

Washington
PO Box 40255
Olympia, WA 98504
(800) 562-6900
www.insurance.wa.gov

West Virginia
PO Box 50540
Charleston, WV 25305
(888) 879-9842
www.wvinsurance.gov

Wisconsin
PO Box 7873
Madison, WI 53707
(800) 236-8517
www.oci.wi.gov

Wyoming
106 East 6th Avenue
Cheyenne, WY 82002
(800) 438-5768
https://doi.wyo.gov

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

IMPORTANT CLAIM NOTICE

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 payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or 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.

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.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

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.

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.

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

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

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.

Puerto Rico Residents: **Caution:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island 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.

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.

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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington 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.