State of Florida Account
Participating Agencies and Departments
Payroll Deduction Code 262

Mail To: **New York Life Group Benefits Solutions**
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free
Claims administered by New York Life Group Benefits Solutions

Group Life Insurance
Total and Permanent Disability / Waiver of Premium Claim Form

GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America

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, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Vermont, Virginia or Washington.***

Section To Be Completed by the Employer/Administrator

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

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

Insured's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced

Occupation *(Please attach a copy of the employee's Job Description)* _____

Was insurance issued on the basis of a statement of physical condition?
(If yes, attach copy) ☐ Yes ☐ No

Please check the appropriate blocks regarding the insured's employment status.
☐ Active ☐ Retired ☐ Salaried ☐ Hourly Hours per week ___ ☐ Hourly ☐ Part-time

Basic Annual Earnings	Date Hired	Date of Last Change in Earnings	Date of Last Increase in Benefits

Date Last Worked	Number of Hours Worked	Effective Date of Insurance	Premium Paid Through Date

Percentage of Employee Contribution Towards Premium
100 %

Employee's Contribution were made on
☐ Pre-Tax or ☒ Post-Tax Basis

Group Policy Number _____ Amount of Insurance _____

Has Employee's/Member's Coverage Terminated? ☐ Yes ☐ No **DATE(S)** _____ **REASON** _____

Employer's/Administrator's Certification

Name of Employer
State of Florida
Department/Agency
E-Mail Address

Address *(Street)* *(City)* *(State)* *(Zip Code)* | 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 of Authorized Representative _____ Date Signed

To Be Completed by the Employee

Date of Accident or Beginning of Sickness	E-Mail Address	Did you apply for conversion of your Group Policy? ☐ Yes ☐ No If "yes", please provide policy number and effective date:

Name other sources of income to which you and your dependents are entitled by checking the appropriate sources listed below. Please indicate below the current status of Social Security Disability/Retirement benefit (check appropriate status). If you are receiving Social Security benefits, please provide us with a copy of the most recent decision (Award or Denial).

☐ Social Security
☐ Awarded ☐ Denied/No appeal has been filed ☐ Denied/Filed for Reconsideration ☐ Denied/At Administrative Law Judge Level
☐ Other (Comments) _____

☐ Pension
☐ Governmental
☐ Worker's Compensation _____ (Identify Insurance Carrier) _____ (Policy Number)
☐ Disability Insurance _____ (Identify Insurance Carrier) _____ (Policy Number)

Describe in your own words what is wrong with you. (If accident, describe circumstances)

To Be Completed by the Employee (Continued)

Education

Level of Education Completed *(insert number 1-12)*: ___

High School Diploma ☐ Yes ☐ No

G.E.D. ☐ Yes ☐ No

Vocational, Business or Correspondence School (name, address, courses)

Name: _____ Name: _____

Address: _____ Address: _____

Courses: _____ Courses: _____

Certificates or Special Licenses: _____

College Education Completed *(insert number 1-6)*: ___

Major(s)

Degree(s)

U.S. Military or Naval Science ☐ Yes ☐ No

If Yes, Special Training

Work History

Employer

Address

Date Started

Date Left

Reason

Job Title

Job Duties

Salary $

Employer

Address

Date Started

Date Left

Reason

Job Title

Job Duties

Salary $

Employer

Address

Date Started

Date Left

Reason

Job Title

Job Duties

Salary $

Medical History

Please list any hospitals, clinics or physicians that treated you during the last 3 years. (Attach a separate sheet of paper, if needed)

Name

Address

Telephone

Treatment Period(s)

Type of Treatment(s)

Currently Treating You? ☐ Yes ☐ No

Name

Address

Telephone

Treatment Period(s)

Type of Treatment(s)

Currently Treating You? ☐ Yes ☐ No

Name

Address

Telephone

Treatment Period(s)

Type of Treatment(s)

Currently Treating You? ☐ Yes ☐ No

Are you able to take care of all your personal care needs (grooming, dressing, etc.)? If no, what areas require assistance?

Please indicate the chores you perform on a regular basis (check all that apply)

☐ Cooking ☐ Shopping ☐ Laundry ☐ Cleaning ☐ Child Care ☐ Yard Work, Gardening ☐ Other _____

Do you go for walks? ☐ Yes ☐ No If yes, how often and how far do you walk? _____

Employee's/Association Member's Certification

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

Signature of Employee _____ Date Signed _____

The issuance of this blank 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 in the premises.

GROUP BENEFIT SOLUTIONS

Mail To: **New York Life Group Benefit Solutions**
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

Life Insurance Company of North America

Group Life Claim Form Waiver of Premium

Physician's Statement of Disability (Please Print)

Please complete all relevant sections as thoroughly as possible and include medical documentation to support your findings.

This Section Is To Be Completed by the Patient/Insured			
Name	Employer Name		Social Security Number
Address (Street)	(City)	State	Zip Code
Group Policy Number	Telephone Number	Occupation	Date of Birth

The Remaining Sections of this Form Are To Be Completed By Your Physician(s)

1. Diagnosis (Including any complications) (a) Diagnosis (Include ICD or DSM Code)

(b) Subjective symptoms

(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)

(d) Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain

(e) Is illness work related? ☐ Yes ☐ No

(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____

2. Dates of Treatment

(a) Date patient first visited you for this accident/illness: *(Month/Day/Year)*

(b) Date patient first unable to work due to this accident/illness: *(Month/Day/Year)*

(c) List frequency and date(s) patient was examined for this accident/illness:

(d) Date of last visit: *(Month/Day/Year)*

3. Nature of Treatment (Including Surgery & Medications prescribed, if any)

(a) Hospitalization on: *(Month/Day/Year)* **Through** *(Month/Day/Year)*

(b) Surgery on: *(Month/Day/Year)* Type of Surgery:

(c) Name and Address of Hospital

(d) **Medications**	**Type**	**Dosage**

816175 Revised 05/2025

4. Physical Limitations / If Applicable: In an 8-hour work day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently

Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** - 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. Mental Impairment / If Applicable - Please complete the following (incomplete information will delay claim processing):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF in past year: _____ Baseline: _____

Additional Comments:

6. Return to Work Status	**Patient's Regular Occupation**	**Any Other Occupation**
When was patient able to go to work?	☐ Full-time ☐ Part-time _____ Month/Day/Year	☐ Full-time ☐ Part-time _____ Month/Day/Year

7. Remarks

Physician Name *(Please Print)*:	Degree and Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number:	Federal Tax ID Number:
Physician Signature: _____	Date: _____

GROUP BENEFIT SOLUTIONS

Disclosure Authorization

Claimant's Name: _____

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; New York Life Group Insurance Company of NY or New York Life Insurance and Annuity Corporation (Life Insurance Company of North America and New York Life Group Insurance Company of NY or New York Life Insurance and Annuity Corporation shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide its services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature) _____ (Date Signed) _____

(Print Name) _____ (Date of Birth) _____

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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.

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.

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.

Vermont Residents: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.