Life Insurance Program from

New York Life Insurance Company
P.O. Box 30713
Tampa, FL 33630-3713
(800) 695-5165

We're here to help with your Waiver of Premium benefit request.

We know what a difficult time it can be when you or a loved one enters a nursing home. The Waiver of Premium benefit is a part of many of our life insurance products specifically for that reason ... to help provide some relief and peace of mind during this time. Here is all you will need to begin your request for the Waiver of Premium benefit.

How to submit your Waiver of Premium benefit request:
Your first step is to complete and return a Waiver of Premium Claim Form, which is enclosed with this letter. You'll need to have the appropriate parties fully complete and sign each section of the form.

- **Insured's Statement:** to be completed and signed by the claimant/insured.*
- **Physician's Statement:** to be completed and signed by the insured's doctor.
- **Nursing Home Statement:** to be completed and signed by the administrator of the nursing home or facility. If you need to include multiple facilities in your claim request, you can use additional blank forms and have the administrator for each facility complete this section. Simply make copies of the enclosed form, download them at nylaarp.com/service, or contact us to request more.
- **Medical Information and Medical Authorization:** this section needs to be completed and signed by the claimant/insured.*

*If a legal representative such as a court-appointed Guardian or Power of Attorney (POA) completes these sections on behalf of the claimant/insured, you'll need to include a complete copy of their authorizing documents with the claim form. Please note that Durable or Financial POAs will be considered, however, a Health Care Proxy is not an acceptable POA designation.

Within 30 days, mail all documents to New York Life at the address listed at the top of this letter, or fax to (855) 381-5010.

What happens next:
After we receive the completed form, we'll begin the review, then contact you if we have any questions or once a determination has been made. Please be sure to continue paying premiums until the review is complete, so the contract doesn't lapse and end coverage.

Please return all required forms as soon as possible.
If you don't return the completed form within 30 days, we will consider this request for the Waiver of Premium benefit closed. You may submit the forms at a later date and we will consider your request for the Waiver of Premium Benefit at that time.

If you have questions about filing your Waiver of Premium Claim Form or the status of your request:
We are here to help. Please don't hesitate to contact us at (800) 695-5165, Monday through Friday, from 8:00 a.m. to 5:00 p.m. (Eastern Time).

Sincerely,
Claims Services
AARP Life Insurance Program
New York Life Insurance Company

Fraud Statements

Arizona
For your protection Arizona law requires the following 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
For your protection California Law requires the following to appear on this form: 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.

Colorado
It is unlawful to knowingly provide false, incomplete 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
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.

Florida
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.

Maryland
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 may be subject to fines and confinement in prison.

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

New York
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.

Oregon
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 may be subject to prosecution for insurance fraud. Any person who provides misinformation material to the content of the contract, which is relied upon by the insurer, and which is either material to the risk assumed by the insurer or provided fraudulently, may be subject to the denial of insurance benefits.

Pennsylvania
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
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 with the penalty of 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.

Other States
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 may be subject to fines and confinement in prison.

AARP® Life Insurance Program from NEW YORK LIFE

AARP Life Insurance Program
New York Life Insurance Company
Claims Service
P.O. Box 30713
Tampa, FL 33630-3713

Waiver of Premium Claim Form

Insured's Statement

To be completed by the **claimant/ insured.**

- IMPORTANT -
If this section is completed on the insured's behalf by a legal representative such as a court-appointed Guardian or Power of Attorney (POA), include a complete copy of the authorizing documents with the claim form. **Note:** Durable or Financial POAs will be considered, however, a Health Care Proxy is not an acceptable POA designation.

Contract Number | Date of Birth

First Name | Middle Initial | Last Name

Address | City | State | Zip Code

☐ ***Check here*** *if you'd like future correspondence sent to this address. If not, provide the address for future correspondence.*

Address | City | State | Zip Code

( ) Phone Number | ( ) Alternate Phone Number

Name of Nursing Home(s)

Date you entered the facility | Date discharged from the facility

I have read and understand the fraud warning in the "State Variations of Fraud Warnings" applicable to the state in which I reside.

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.

Signature of Insured or Legal Representative | Date

Physician's Statement

To be completed by the **doctor of the insured.**

Physician | ( ) Phone Number

Address | City | State | Zip Code

Did a physician recommend the patient to enter the nursing home? ☐ Yes ☐ No

Briefly describe the patient's current medical condition and prognosis.

Physician's Signature | Date

Nursing Home Statement

To be completed by the **facility administrator.**

If you would like to include more than one nursing home confinement in your claim, make a copy of this form and have the administrator of each facility complete this section. You can also download blank copies at nylaarp.com/service, or contact us.

Facility | ( ) Phone Number

Address | City | State | Zip Code

Date of patient's confinement in facility: From ______ To ______

Is this facility approved for payment of Medicare/Medicaid benefits or qualified to receive such approval? ☐ Yes ☐ No

Does this facility provide continuous 24 hour a day nursing service by or under the supervision of a registered professional nurse (RN)? ☐ Yes ☐ No

Does this facility maintain daily medical records of each patient? ☐ Yes ☐ No

Is this facility primarily engaged in providing skilled nursing care under the supervision of a duly-licensed physician? ☐ Yes ☐ No

Administrator's Signature | Print Name | Date

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Medical Information

- IMPORTANT -

If this section is completed on the insured's behalf by a legal representative such as a court-appointed Guardian or Power of Attorney (POA), include a complete copy of the authorizing documents with the claim form. **Note:** Durable or Financial POAs will be considered, however, a Health Care Proxy is not an acceptable POA designation.

> List the information below for all physicians, hospitals, or other medical facilities who provided treatment within the past five years.

Doctor/ Hospital Name	Street Address City, State & Zip Code	Phone Number	Dates	Condition

Medical Authorization

I give permission to release information concerning *(name of insured)* ____________________ to New York Life including its agents, attorneys, reinsurers, and insurance support groups acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol abuse, other insurance coverage, financial and employment history. This information may be released by medical professionals or facilities, pharmacies, pharmacy benefit managers, government offices, employers, insurance companies, insurance support groups, group policy holders, or benefit plan administrators. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. I understand that my claim will not be processed unless this authorization is valid from the date signed until the claim is resolved, except in those states, which allow for only a one-year limit.

I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on this authorization. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

Insured/Legal Representative's Signature Date