



INSURED'S SUPPLEMENTAL APPLICATION FOR DISABILITY INCOME BENEFITS

TO ENABLE US TO EXPEDITE CONSIDERATION OF YOUR CLAIM: Use this form to report your status since the last report. If you need additional space to answer any of the questions, attach a sheet of paper with your additional answers. Please fully answer each question, sign and date all forms and attachments and return the originals to us. Failure to complete all the questions or sign and date the claim form(s) will result in a delay in the consideration of your claim.

1. Name: _____ Social Security #: _____-_____-_____
2. Current Residential Street Address: _____

Telephone Number: (____) _____

3. Name and address of the doctor currently treating your medical condition: _____

4. When did you last consult your doctor? ____/____/____
5. When is your next scheduled appointment for treatment or evaluation by your doctor? ____/____/____
6. List the names of all other physicians or medical practitioners, hospitals or institutions by whom, or in which, you were attended, treated or examined during the past 12 months for this or any other medical condition.

NAME	ADDRESS	DATES OF ATTENDANCE	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Are you currently working in any occupation on any basis? Yes No
(If "Yes", provide the name and address of the business and details regarding your work activities, including type of job, your job duties, number of hours worked and the date your started working:_____
8. If you have not returned to work, when do you expect to return to work? ____/____/____
9. What are your daily activities? _____
10. List your current restrictions and limitations, if any, due to your medical condition. *(If none, state "NONE")* _____

*In furnishing this form, New York Life does not admit the validity of this claim or waive any of its rights or defenses.
Your eligibility for benefits will be determined in accordance with the terms of the specific policy contract.*

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 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.

DECLARATION AND SIGNATURE

I declare that the answers provided on each page of this form and any attachments are complete and true to the best of my knowledge and belief. I understand that New York Life and Pearl Carroll & Associates LLC., their representative, reserves the right to require further information in order to evaluate my claim.

Insured's signature (Insured or Insured's authorized representative) _____
Relationship if other than Insured

Date Signed: _____