Pearl Carroll & Associates LLC
12 Cornell Road
Latham, NY 12110

Fax # 518-640-8105

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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: _____

ATTENDING PHYSICIAN'S STATEMENT – PROGRESS REPORT

(The patient is responsible for the completion of this form without expense to the Company. Please fully answer each question. Attach additional sheets if necessary.)

GROUP _____ PATIENT'S SOCIAL SECURITY NO OR ID _____

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

2. CURRENT MEDICAL CONDITION(s):

   PRIMARY DIAGNOSIS: _____ ICD-10 CM CODE: _____

   SECONDARY DIAGNOSIS:_____ ICD-10 CM CODE: _____

3. DATES YOU HAVE PROVIDED TREATMENT TO THE PATIENT SINCE YOUR LAST REPORT TO US:
   _____

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

5. HAS PATIENT BEEN HOSPITALIZED SINCE THE DATE OF YOUR LAST REPORT TO US? YES ☐ NO ☐ ***(If "YES", provide reason, hospital name and address and dates of confinement):***
   _____

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

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

8. 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? ___/___/_____

9. 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)***_____
   _____

10. BASED ON YOUR OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

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

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

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

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

    IF "YES" DATE RELEASED RELEASED FROM YOUR CARE: _____/_____/_____ (MO) (DAY) (YEAR)

    IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: _____/_____/_____ (MO) (DAY) (YEAR)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTINAING 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 STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

ATTENDING PHYSICIAN'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/SPECIALTY (PLEASE PRINT) TAX ID/SOCIAL SECURITY # TELEPHONE NUMBER

_____ _____ _____
STREET ADDRESS CITY STATE ZIPCODE PROVIDER'S SIGNATURE DATE SIGNED

Please mail to: Pearl Carroll & Associates LLC
12 Cornell Road – Disability Unit
Latham, NY 12110