GROUP DISABILITY INCOME INSURANCE
CLAIMANT'S SUPPLEMENTAL CERTIFICATION

FAX forms to: **518-640-8105** or EMAIL to: **CLAIMS@PEARLINSURANCE.COM**
or MAIL to: PEARL INSURANCE – CLAIMS DEPARTMENT, 13 AIRLINE DR, ALBANY, NY 12205

TO EXPEDITE CONSIDERATION OF THIS CLAIM: Use this form to report claimant's status since the last report. If additional space is needed to answer any of the questions, attach a sheet of paper with additional answers. Please **FULLY ANSWER** each question, sign and date this form where indicated. Failure to complete all questions or sign and date the form may result in processing delays.

Claimant Name (Last, First, MI)		Social Security Number XXX - XX -	Date of Birth
Member (Policy Owner) (if other than claimant)	Name (Last, First, MI)	Social Security Number XXX - XX -	Date of Birth

Mailing Address (Street, Apt #, City, State, Zip)

Email Address Daytime Phone (check one) ☐ Mobile ☐ Home ☐ Work

Name and address of physician currently treating claimant's medical condition:

Date of last treatment for condition: _____ Next scheduled appointment for treatment: _____

Is claimant currently working in any occupation on any basis, including self-employment? ☐ Yes ☐ No

If yes, provide name(s) of employer(s) and / or details of self-employment, type of job or job duties, and date started working:

If claimant has not returned to work, provide estimated return date: _____

List claimant's current restrictions and limitations, if any, due to his or her medical condition (if none, indicate "none"):

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

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.

I have read and understand the terms and requirements of the fraud warnings included as part of this form. I certify that the answers provided on all pages 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 Insurance, their representative, reserves the right to require further information in order to evaluate this claim.

Member's (Policy Owner's) Signature Date (MM DD YYYY)