PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
CLAIMS DEPT FAX: 412-963-0148
claims@providentins.com

Dear Beneficiary:

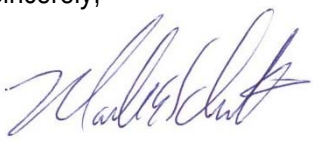
Please accept our condolences on your recent loss. We understand this is a difficult time, and we hope that we can alleviate any concerns you may have about your claim.

To help process your claim in the fastest possible manner, Provident on behalf of New York Life Insurance Company is providing this easy to use Claim Form for your convenience. Please review the form in its entirety, and then follow the step-by-step instructions to submit your claim.

Provident prides itself on the speed with which we pay claims. Please return the completed Claim Form, death certificate and any additional documents that we may request, so we can process your benefit promptly.*

Please be assured that Provident will act as quickly as possible to complete the processing of your claim once we receive all the necessary information and documentation. Please feel free to contact Provident's claim center if you have any questions.

Sincerely,



Mark E. Schmitt
Vice President of Operations

CLAIM FORM FOR LIFE INSURANCE PROCEEDS

*This claim form may have been sent before Provident on behalf of New York Life has determined whether any insurance was in force at the time of death and to whom the proceeds are payable. New York Life retains the right to make such determination.

HOW TO COMPLETE YOUR CLAIM FORM

Please read this before you start to complete your Claim Form

To facilitate the processing of your claim, please send us a fully completed Claim Form from each beneficiary, one death certificate and any other documents that we may request. You may use a photocopy of the Claim Form if there is more than one beneficiary. **No original documents will be returned.**

GROUP CERTIFICATE INFORMATION

Please be sure to enter all certificate numbers on the Claim Form and enclose all the original insurance certificates, if available. If not available, please explain.

DECEASED INFORMATION

Information about the deceased is necessary for purposes of identification and benefit determination.

BENEFICIARY INFORMATION

Information about the Beneficiary is necessary for claims processing.

Taxpayer Identification Number: Life insurance benefits are generally not subject to income tax. However, New York Life pays interest on all proceeds from the date of death. Since the interest paid to you may be taxable, you should consult your tax advisor.

The Federal government requires us, and all other financial institutions, to report interest we pay you. Therefore, we are required to obtain your Social Security Number or Taxpayer Identification Number, which you must certify under penalties of perjury. If you are applying for a tax number, please write, "applied for" in the appropriate space. If you fail to supply us with an identification number, the Federal government requires us to withhold a portion of your interest as a deposit against the taxes that may be due.

Some persons have been notified by the Internal Revenue Service that they are subject to "backup withholding" because in the past they did not report all their interest or dividends. If you have been so notified, and a backup withholding order has not been rescinded, you must check the Backup Withholding statement right below your Income Tax Certification. We may contact you for more information if there are any questions about your Taxpayer Identification Number or backup withholdings status, or if you are a non-resident alien or foreign entity.

- **Claims by an Estate:** If an Executor or Administrator is filing the claim, he or she must sign the Claim Form and submit a certified copy of the appointment papers. Be sure to use the Tax Identification Number of the Estate. Note: A Last Will and Testament will not be accepted as proof of authority of executorship.
- **Assignment:** If you have assigned all or any portion of the claim to a funeral home for final expenses, please include a copy of that assignment. If the deceased assigned the policy proceeds to a bank or other financial institution, an authorized representative of that institution must sign the Claim Form.
- **If the Beneficiary is a Minor:** If there is a legal guardian for a minor, he or she should sign the Claim Form and submit a copy of the court document appointing the custodian of the minor child's property/estate. If no legal guardian has been appointed, payment may be considered under the Uniform Transfers to Minors Act (UTMA) subject to state guidelines. Please contact our office for further information.

YOUR SIGNATURE

Please sign the Claim Form.

MEDICAL INFORMATION AND AUTHORIZATION

Complete this section **ONLY IF** all or any portion of life insurance coverage was issued within two years of the death of the insured, or if you are making a claim for an Accidental Death Benefit.

Illinois Interest Statement

If the certificate was issued in Illinois, you will be paid 10% interest, from the date of death, if your claim is not paid within 31 days of receiving the necessary proof needed to settle the claim.

State Variations of Fraud Warnings

Please refer to the applicable fraud warnings for your state of residence.

Arizona: 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: 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 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: 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 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.

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 the 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.

All Other States: Any person who knowingly and with the 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. Penalties may include imprisonment, fines, or a denial of insurance benefits if a person provides false information.

CLAIM FORM *Please type or print clearly.*
Please return this Claim Form together with the death certificate and any other documentation that we may request to the address the Plan Administrator has provided to you.

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claims@providentins.com

LIST ALL GROUP CERTIFICATE NUMBERS UNDER WHICH YOU ARE MAKING A CLAIM

Are the Group Certificates attached? ☐ **Yes** ☐ **No** **If no, please explain** ☐ **Lost** **Other** _____

LIST ALL POLICYHOLDER NAMES AND POLICY NUMBERS FOR YOUR CLAIM

Policyholder Name (s): _____

Policy Number (s): _____

Is this claim also being made for an Accidental Death Benefit? ☐ Yes ☐ No

If all or any portion of the insurance coverage began within two years of the death of the insured, or if the program contains an Accidental Death benefit and the death was the result of an accident, please complete and sign the Medical Information and Authorization. In case of an accidental death, also send us copies of police or coroner's report and any news articles.

EMERGENCY SERVICE ORGANIZATION/ADMINISTRATOR'S CERTIFICATION – To be completed by the policyholder's point of contact.

Name: _____ Title/Position: _____

Address: _____
Street *City* *State* *Zip Code*

Telephone #: _____ Email Address: _____

Signature: _____ Date: _____

DECEASED INFORMATION – Information related to the member or dependent for which the claim is being made.

Name: _____ **Nickname or Maiden Name:** _____

Date of Birth _____ **Date of Death** _____
Month *Day* *Year* *Month* *Day* *Year*

Manner of Death: ☐ **Natural** ☐ **Suicide*** ☐ **Accident*** ☐ **Homicide*** ☐ **Unknown** ☐ **Other** _____

***Please attach copies of police and coroner's report and any relevant news articles.**

BENEFICIARY INFORMATION – We must have a fully completed Claim Form from each beneficiary.

Name: _____
First *Middle* *Last*

Address: _____
Street *City* *State* *Zip Code*

Home Phone: _____ **Alternate Phone:** _____

Date of Birth: _____ **Email Address:** _____
Month *Day* *Year*

Social Security or Taxpayer Identification Number: _____

In what capacity are you making this claim? ☐ **Beneficiary** ☐ **Executor** ☐ **Trustee** ☐ **Other** _____

Relationship to Deceased: ☐ **Spouse** ☐ **Child** ☐ **Parent** ☐ **Other** _____

YOUR SIGNATURE

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.

Under penalties of perjury, I certify: (1) My Social Security Number or Tax ID shown on this form is my correct taxpayer identification number, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding, (3) I am a U.S. person (includes a U.S. resident alien), and (4) The (FATCA) code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. (Please note: if being submitted for a U.S. account, this last certification (4) does not apply.)

☐ Check this box if the IRS has notified you that you are subject to backup withholding.

If you are not a U.S. citizen, U.S. resident alien or other U.S. person, you must submit the applicable Form W-8 with this form to certify your foreign status and, if applicable, claim treaty benefits.

If you are not a U.S. person, your signature below only applies to the provisions of this document other than the provisions contained in this Owner Tax Certification section.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature (Required) ***Date***

MEDICAL INFORMATION AND AUTHORIZATION

HIPAA-Compliant Authorization
To expedite the processing of your claim, please complete this page in its entirety.
Complete if
(a) the death occurred within two years of the issue date or reinstatement date,
(b) the death was due to an accident and the policy contains the Accidental Death Benefit, or
(c) if specifically requested.

Physician /Doctor Name	Address, City, State, Zip Code	Telephone Number	Dates	Condition

MEDICAL AUTHORIZATION:
I give my permission to release information concerning _____who died on _____
Name of Insured
to New York Life Insurance Company including its agents, affiliates or subsidiary companies and attorneys, reinsurers, insurance support groups and independent administrators who are acting on their behalf ("New York Life"). Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol use, other insurance coverage, financial and employment history, driving records, or information otherwise needed to determine policy claim benefits due but excludes psychotherapy notes. This information may be released by medical professionals or facilities, pharmacies, pharmacy benefit managers, government offices, employers, insurance companies, insurance support groups, group policyholders or benefit plan administrators, any consumer reporting agency, the Social Security Administration, the Internal Revenue Service, the Veteran's Administration, or any other organization or person having any knowledge of the above-named Insured. When requesting information from any of the sources named above, a copy of this form is as valid as the original. I am aware that any information obtained will be used to evaluate my claim.

Either I, or a person I choose, am entitled to receive a copy of this authorization. This authorization is valid from the date signed until the claim is resolved, except in those states that 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 agencies. In this case, the information may no longer be protected by the rules governing this authorization.

Signature ***Relationship to Insured*** ***Date***