Click here to clear form

GROUP LIFE INSURANCE CLAIM PACKET
(Accelerated Benefit)

SYMETRA® RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

You Can Help Ensure a Quick Claim Decision

- ✓ All required claim forms must be signed, dated and completed fully and accurately.
- ✓ Provide all supporting documentation as required:
  - Copies of all enrollment and beneficiary forms completed by the member, not just the most recent form(s). This would include enrollment forms from other carriers which were completed prior to the First Symetra policy.
  - Verification of Earnings as defined in your policy, if claim is in excess of $100,000.00 and a benefit amount is based on earnings.

Policyholder's Instructions for Filing a Group Life Accelerated Benefit Claim

Please submit the following to expedite claim review:

MEMBER or DEPENDENT CLAIM

- ☐ **Policyholder's Group Life Accelerated Benefit Statement** fully completed by the policyholder.
- ☐ **Member's Group Life Accelerated Benefit Statement** fully completed by the member.
- ☐ Copies of **all enrollment forms** completed by the member (including forms completed prior to the First Symetra policy effective date) and change of beneficiary forms completed by the member.
- ☐ If the benefit is based on **earnings** and the total claim is more than $100,000.00, provide proof of earnings as of the period specified in your policy's Earnings definition.
- ☐ **Authorization for Release of Medical Information** fully completed by the member (or dependent if a dependent claim and the dependent is not a minor).
- ☐ **Attending Physician's Statement** – Accelerated Benefit form completed by the member (or dependent if a dependent claim and the dependent is not a minor) and the treating physician.
- ☐ Review the Fraud Warning Notices for your state.

Mail documents to:
First Symetra National Life
Insurance Company of New York
Claims Department
PO Box 1230
Enfield, CT 06083-1230

If you should need assistance in submitting the claim, please contact the Life and Absence Management Center at 1-877-377-6773 or email LADCLA@symetra.com. Additional information may be required.

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650
www.symetra.com

POLICYHOLDER'S GROUP LIFE ACCELERATED BENEFIT STATEMENT

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.

Group Policy Number _____

Policy benefit amount(s): ☐ Employee Basic Life $ _____ Supplemental Life $ _____
☐ Dependent Basic Life $ _____ Supplemental Life $ _____

Accelerated amount(s) requested (if known): Basic Life $ _____ or _____% Supplemental Life $ _____ or _____ %

Note: The amount being requested may not exceed the percentage or dollar amount of the Member's Life Insurance Amount set forth in the policy and is subject to the minimum amount.

A. INFORMATION ABOUT THE MEMBER

1. Member's name _____ Life Insurance Class _____
   (This information is required. Refer to your policy.)
2. Address _____
3. Social Security number _____ Date of birth _____
4. Hours worked per week _____ ☐ FT ☐ PT If benefit is based on Earnings, provide salary used to calculate benefit amount $_____ per ☐ hour ☐ week ☐ month ☐ year Salary effective on _____
5. Date employed _____ Occupation _____ Department/Location _____
6. Member's coverage effective on _____ Provide date Members' premium was last paid _____
7. Provide date Member last worked _____ and reason why (layoff, illness, FMLA, etc.) _____
8. Has employment been terminated? ☐ Yes ☐ No If yes, provide date employment terminated _____
   Was portability applied for? ☐ Yes ☐ No ☐ Unknown Was conversion applied for? ☐ Yes ☐ No ☐ Unknown

B. INFORMATION ABOUT THE DEPENDENT (Answer only for a Dependent illness)

1. Name of dependent _____ Dependent SSN _____
2. Relationship to Member _____ Effective date of dependent coverage _____
3. Provide date Dependent's premium was last paid _____

Do you recommend payment of this claim? _____ Remarks _____

I hereby certify:

- That the above member meets the eligibility requirements of the policy and is insured under the policy.
- I am not related to the member.
- I am an authorized representative of the policyholder and confirm that the above statements are true.
- I have read the attached fraud notices.

Name of Policyholder _____

Address _____

Phone _____ Fax _____ E-mail address _____

Signature _____ Print name _____

Title _____ Date _____

Please read the following notice that we are required by law to give to you.

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DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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 civil fines and criminal penalties.

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POLICYHOLDER'S FREQUENTLY ASKED QUESTIONS

Q: What happens after the claim has been submitted?
A: The claim will be assigned to a Life Claim Specialist the day it is received. A letter acknowledging receipt of the claim is sent to the policyholder and member. Within 24-48 hours, the claim will be reviewed. If additional information is needed to make a claim determination, it will be requested from the policyholder or the member.

Q: How long does it take for a claim to be paid?
A: Once all necessary information is obtained, payment usually takes less than five business days. Payment is sent directly to the member and written notice of the payment is sent to the policyholder.

Q: Who do I contact if I have a question about a filed claim?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgement letter.

Q: How can I check the status of my claim?
A: Contact First Symetra by phone at 1-877-377-6773 or visit www.symetra.com/GO and log in to view your claim data if you are a registered user. If you are not a registered user, select *New User Registration* to begin the registration process.

Q: What do I do if an enrollment form or beneficiary form is not available?
A: Proceed with submitting the claim with the documents that you have in your possession. Provide a note with the claim explaining that you have no enrollment or beneficiary forms and why.

Q: If the member is not able to work due to the terminal illness, should a waiver of premium claim be filed?
A: We will automatically open a claim if the member is unable to work due to the terminal illness. You and the member will be notified of the waiver of premium claim determination once the waiver elimination period specified in the policy ends.

Q: What if the claim is denied?
A: First Symetra sends an explanation letter to the member along with instructions on how to file an appeal if the member disagrees with our decision. The policyholder will receive written notice that the claim or a benefit has been denied. If we receive additional information to support the original claim, a Life Claim Specialist will re-open the claim. If no additional information has been provided to support the original claim and a reversal of the denial, the file will be assigned to an Appeals Specialist for further review.

SYMETRA® RETIREMENT | BENEFITS | LIFE
FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Claims Department
Home Office: 420 Lexington Ave, Suite 300
New York, NY 10170-0399
Mailing Address: PO Box 1230 | Enfield, CT 06083

Phone 1-877-377-6773 | Fax 1-877-737-3650

MEMBER'S GROUP LIFE ACCELERATED BENEFIT STATEMENT

INSTRUCTIONS TO THE MEMBER

- Fully complete and sign this form.
- The terminally ill person or his or her legal guardian complete:
  - The Authorization for Release of Information (LGC-85/NY).
  - Part A of the Attending Physician's Statement – Accelerated Benefit form (LB-1057/NY) and have his or her treating physician complete Part B.
- Mail these documents to the address at the top of this claim form.

IMPORTANT TAX INFORMATION: The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor and/or legal advisor before you apply for an Accelerated Benefit.

Group Policy Number _____

Accelerated amount(s) requested: Basic Life $ _____ or _____ %

Supplemental Life $ _____ or _____ %

Note: The amount being requested may not exceed the percentage or dollar amount of the Member's Life Insurance Amount set forth in the policy, and is subject to the minimum and maximum amounts.

A. INFORMATION ABOUT THE MEMBER

1. Member's name _____ ☐ Male ☐ Female
2. Address _____
3. Social Security number _____ Date of birth _____
4. Home phone number _____ Cell phone number _____

B. INFORMATION ABOUT THE DEPENDENT (Answer only for a Dependent Claim)

1. Dependent's name _____ Date of birth _____
2. Relationship to Member _____ ☐ Spouse ☐ Child ☐ Other _____
3. If the dependent is your spouse, provide date of marriage _____
4. If the dependent is your child, answer the following:
   a. Was the dependent child attending school? ☐ Yes ☐ No
   b. If yes, ☐ full time ☐ part time Name of school _____
   c. Was the dependent child working full time? ☐ Yes ☐ No

C. INFORMATION ABOUT THE TERMINAL ILLNESS

1. Date first treated _____ Date illness was first diagnosed _____ Date last seen _____
2. Diagnosis _____
3. What is your understanding of your medical condition? Please describe:

_____

_____

_____

_____

_____

4. Name, address and phone number of your physician(s) – please print and attach additional pages if needed.

Name	Address	Phone	Dates seen

5. Name, address and phone number of hospital where you were treated.

Hospital name _____ Phone _____

Address _____

Date admitted _____ Date discharged _____

☐ Check this box if you have been notified by the Internal Revenue Service that you are subject to backup withholding on interest and dividends, under provisions 3406(a)(1)(c) of the Internal Revenue Code.

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect the eligibility of you and/or your spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to apply for such benefits, you should seek assistance from a qualified tax advisor.

No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

The remaining death benefits, if any, will be available to the beneficiary.

The insurer is prohibited from paying accelerated death benefits to you for a period of 5 days from the date on which the preliminary information and illustrations are transmitted in writing to you.

I certify, under penalty of perjury, that the information I have provided in this Statement is true, correct, and complete to the best of my knowledge. I also certify that this application is voluntary and without coercion on the part of any third party. I have read the fraud notice below.

NY: 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 _____ Date _____

Print name _____

The undersigned acknowledges and consents to this accelerated benefit claim; that if approved, payment of the accelerated benefit shall be made to the insured or his/her legal representative; and in consideration of such payment the undersigned agrees that the liability of First Symetra National Life Insurance Company of New York under the policy shall be discharged by the amount of the accelerated benefit paid.

Signature of Spouse _____ Date _____

Signature of Irrevocable Beneficiary _____ Date _____

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SYMETRA® RETIREMENT | BENEFITS | LIFE | FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Claims Department
PO Box 7166 | Bedminster, NJ 07921

Phone 1-877-377-6773 | Fax (908) 655-2394
www.symetra.com

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to First Symetra National Life Insurance Company of New York, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that First Symetra National Life Insurance Company of New York may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with First Symetra National Life Insurance Company of New York.

This authorization shall remain in force for 24 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to First Symetra National Life Insurance Company of New York. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that First Symetra National Life Insurance Company of New York has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by First Symetra National Life Insurance Company of New York except as authorized by me or as required by law.

This authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, First Symetra National Life Insurance Company of New York may not be able to process my application. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

SYMETRA® RETIREMENT | BENEFITS | LIFE | FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Claims Department
Home Office: 420 Lexington Ave, Suite 300
New York, NY 10170-0399
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650

ATTENDING PHYSICIAN'S STATEMENT

Accelerated Benefit

(Completed at Patient's Expense)

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Group Policy Number_____

PART A — TO BE COMPLETED BY THE PATIENT

Full name Date of birth Social Security number

Address

Home phone number Cell phone number

Please review and sign the Authorization for Release of Medical Information to Symetra Life Insurance Company. We will accept an authorization form preferred by your provider's office in place of the Authorization form.

Signature of Patient _____ Date _____

PART B — TO BE COMPLETED BY PHYSICIAN (Please print)

This form is used to help us determine whether the patient is eligible for an Accelerated Benefit payment of life insurance. We need to evaluate the clinical condition of your patient.

1. DIAGNOSIS AND PROGNOSIS

a. Diagnosis, including any complications _____

b. Date of diagnosis _____

c. Objective findings (objective documentation must be included to support life expectancy) _____

d. Prognosis _____

e. In your professional opinion, does the patient have a terminal condition? ☐ Yes ☐ No

f. In your professional opinion, what is the patient's life expectancy?
☐ 0-6 months ☐ 7-12 months ☐ 13-18 months ☐ 19-24 months ☐ over 24 months

2. HISTORY

a. Date symptoms first appeared or accident happened _____ Date patient was informed of diagnosis _____

b. Has patient had the same or similar condition in the past? ☐ Yes ☐ No

If yes, describe and give dates. _____

_____

_____

3. TREATMENT

a. Date of first visit _____ Date of last visit _____

b. If the patient has been hospitalized, please provide:

_____

Hospital name Phone

_____

Address

_____

Date admitted Date discharged

_____

c. Course of treatment, including medication prescribed and surgery, if any _____

_____

_____

_____

d. List other Treating or Referring Physicians

Name Address Phone

_____

_____

_____

I certify, under penalty of perjury, that I am a licensed physician and that the information I have given is true, correct, and complete to the best of my knowledge.

Signature _____ Name of Physician (Print) _____

Degree/Specialty _____ Phone _____ TIN _____

Address _____

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MEMBER'S FREQUENTLY ASKED QUESTIONS

SYMETRA®
RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

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Q. Who do I contact if I have a question about a filed claim or would like to check the status?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgment letter.

Q: Is an Accelerated Benefit payment taxable?
A: The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor and/or legal advisor before you apply for an Accelerated Benefit.

Q: If I am not able to work, should a waiver of premium claim be filed?
A: You will not need to do anything to initiate a waiver of premium claim. We will automatically open a claim if you are unable to work due to the terminal illness. You will be notified of the waiver of premium claim determination once the waiver elimination period specified in the policy ends.

Q: What if my claim is denied?
A: First Symetra sends an explanation letter to the member along with instructions on how to file an appeal if the member disagrees with our decision. The policyholder will receive written notice that the claim or a benefit has been denied. If we receive additional information to support the original claim, a Life Claim Specialist will re-open the claim. If no additional information has been provided to support the original claim and a reversal of the denial, the file will be assigned to an Appeals Specialist for further review.