Globe Life
Insurance Co. of New York

Life Claims Department
PO Box 8076 | McKinney, TX 75070
f: 405-270-1496 | Claims@Globe.Life

On behalf of Globe Life Insurance Company of New York, we extend our deepest condolences for the loss of your loved one. We're here to support you through the claim process during this difficult time.

Steps to Submit Your Claim

1. Read Claim Fraud Warning

Before completing and signing this claim form, please carefully read the Claim Fraud Warning (pp. 8–9) for the state of New York and for the state where you reside.

2. Complete Life Insurance Claim Form

- **Claimant Statement (pp. 2–3)**
  - Additional Beneficiaries, if applicable (p. 4)

For claims below $50,000:

- **Direct Deposit (EFT) Authorization (p. 5)**
  Note: Claims exceeding $50,000 or without a selected payment option will be paid by check.

If the policy is less than 2 years old, please also complete:

- **Authorization for Release of Deceased's Health Information Pursuant to HIPAA (p. 6)**
- **Statement of Medical Provider (p. 7)**

3. Gather Required Documents

- **Death Certificate:**
  - For claims up to $50,000: A *copy* of the death certificate with cause and manner of death.
  - For claims over $50,000: A *certified* death certificate (with raised or colored seal) with cause and manner of death. A copy may be accepted if it comes directly from a funeral home, funding company, agent, or attorney.
- **Funeral assignment paperwork:** If you signed a document with a funeral home that authorizes us to make a payment directly to them, please provide a copy of that document.
- **For accidental death claims and claims where manner of death is homicide:** Please provide additional documents, including autopsy and toxicology reports, ambulance records, police reports, and dated newspaper articles.
- **Power of Attorney:** If you have a Durable Power of Attorney, Guardianship or Conservatorship, please provide a copy of the appointment papers naming you as the representative for the beneficiary.
- **Court certificate of appointment:** If the proceeds may be payable to an Estate, please provide a Court Order appointing you as the Executor or Administrator of the Estate. If you do not have a Court Order, please submit information regarding the next of kin.

4. Return Completed Claim Form and Additional Documents

Mail to:		Email to:		Fax to:
Life Claims Department PO Box 8076 | McKinney, TX 75070	*-OR-*	**Claims@Globe.Life**	*-OR-*	**405-270-1496**

Need Assistance?

Our dedicated support team is here to help.
Call us at **800-654-5433** for any questions or guidance on submitting your claim.

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Claimant Statement

Before completing and signing this claim form, please carefully read the Claim Fraud Warning (pp. 8–9) for the state of New York and for the state where you reside.

Policy Information

Policy Number(s) for this claim *(list all entries, separate with a comma)*

Is any policy less than two years old? *(if No, complete pp. 2–4 only, if Yes, additionally complete pp. 6–7)*

☐ **No** ☐ **Yes**

About the Deceased

Deceased's Full Name *(please print)*

Is the deceased known by any other name? (*if Yes, list all that may apply: e.g. maiden name, hyphenated name, nickname, etc.)*

☐ **No** ☐ **Yes**

Residence Address of Deceased Insured at Death *(street address, city, state, ZIP)*

Social Security Number	Date of Birth / /	Date of Death / /	Union/Local or Worksite, if applicable

Cause of Death *(select one)*

☐ Accident* ☐ Cancer ☐ Heart Disease ☐ Homicide* ☐ Respiratory Disease
☐ Suicide ☐ Unknown -*OR*- Undetermined ☐ Other _____

*If the death was ruled an accident or homicide, please attach the autopsy, toxicology, police reports, a copy of the coroner's report, and copies of dated newspaper articles as applicable.

About the Beneficiary/Claimant

Beneficiary's Full Name *(please print)*		Date of Birth / /	Age**
Relationship to Deceased	Social Security Number	Phone Number	Email Address

Address *(street address, city, state, ZIP)*

**If the above beneficiary is a minor child, please provide a copy of their birth certificate and any applicable custodial documents.

Claimant Statement continues on Page 3

Claimant Statement Continued

Certification

You certify the following by signing this document:

- The information you have provided – in its entirety – is true, complete, and accurate to the best of your knowledge.
- In the event we overpay you, we reserve the right to reclaim the total amount we overpaid. Examples of when we can reclaim the overpayment include, but are not limited to: (i) if we discover we have paid you more than your life insurance claim entitles you to, or (ii) if payment was meant for someone else but was instead paid to you. You agree to repay us the amount we overpaid. If you do not repay us, you understand that we may take steps, including but not limited to, legal action to recover the overpayment in full.
- You have thoroughly read and understand the Claim Fraud Warnings (pp. 8–9) included with this form.

Tax Certification

Failure to complete this section may subject you to backup withholding.

Under the penalties of perjury, I certify:

(i) That the number shown as my Social Security Number in the "About the Beneficiary/Claimaint" section on the previous page is my correct taxpayer identification number, and; (ii) That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and; (iii) I am a U.S. citizen, resident alien, or other U.S. person*, and; (iv) I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

Please note: If the Internal Revenue Service (IRS) has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return, you are required to cross out item (ii) above.

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

The IRS does not require your consent to any provision of this document other than the certificates required to avoid backup withholding.

*If you are not a U.S. citizen, a U.S. resident alien, or other U.S. person for tax purposes, complete and submit form W-8BEN (for individuals) or W-8BEN-E (for entities).

New York Fraud Warning: 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 of Beneficiary _____ **Date Signed** _____

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Additional Beneficiary

Before completing and signing this claim form, please carefully read the Claim Fraud Warning (pp. 8–9) for the state of New York and for the state where you reside.

Policy Number(s) for this claim *(list all entries, separate with a comma)*

Beneficiary's Full Name *(please print)*			Date of Birth / /	Age*
Relationship to Deceased	Social Security Number	Phone Number	Email Address	

Address *(street address, city, state, ZIP)*

*If the above beneficiary is a minor child, please provide a copy of their birth certificate and any applicable custodial documents.

Certification

You certify the following by signing this document:

- The information you have provided – in its entirety – is true, complete, and accurate to the best of your knowledge.
- In the event we overpay you, we reserve the right to reclaim the total amount we overpaid. Examples of when we can reclaim the overpayment include, but are not limited to: (i) if we discover we have paid you more than your life insurance claim entitles you to, or (ii) if payment was meant for someone else but was instead paid to you. You agree to repay us the amount we overpaid. If you do not repay us, you understand that we may take steps, including but not limited to, legal action to recover the overpayment in full.
- You have thoroughly read and understand the Claim Fraud Warnings (pp. 8–9) included with this form.

Tax Certification

Failure to complete this section may subject you to backup withholding.

Under the penalties of perjury, I certify:

(i) That the number shown as my Social Security Number in the "Additional Beneficiary" section above is my correct taxpayer identification number, and; (ii) That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and; (iii) I am a U.S. citizen, resident alien, or other U.S. person**, and; (iv) I am not subject to FATCA reporting because I am a U.S. person** and the account is located within the United States.

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Signature of Beneficiary **Date Signed**

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Direct Deposit (Electronic Funds Transfer or EFT) Authorization

If your claim is **under $50,000,** you can choose to receive your life insurance proceeds by check or direct deposit. To have your life claim payment(s) sent directly to your bank account via Direct Deposit (Electronic Funds Transfer or EFT), please provide the following information.

For claims of **$50,000 or more**, payment will be made by check only.

By electing Direct Deposit, you agree and understand that:

- All payments so made shall discharge Globe Life to the extent of the payments;
- All claim payments will be made via Direct Deposit, whether you submit claims electronically or by mail;
- If we are unable to send your payment(s) via Direct Deposit to the bank account provided, we will send a check to the address of record; and
- You will receive claim-related correspondence, such as Explanation of Benefits (EOB), by mail.

Please indicate your settlement option choice below

☐ Check

☐ Direct Deposit

Account Holder Name *(as it appears on your bank account)*

Type of Account	Account Number	Routing Number
☐ Checking ☐ Savings		

Bank Name

By signing below, I hereby authorize Globe Life to initiate credit entries to the Bank indicated by the Transit Number on this form. If necessary, I also authorize debit entries and adjustments for any credit entries in error to my account indicated on this form. This authority is to remain in full force and effect until Globe Life has received written notification from me of its termination. The written notification must be in such time and manner as to afford Globe Life and the Bank a reasonable opportunity to act on it.

Signature of Beneficiary **Date Signed**

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Authorization for Release of Deceased's Health Information Pursuant to HIPAA

All fields in this form are required.

Deceased's Full Name *(please print)*	Date of Birth / /	Social Security Number

Policy Number(s) for this claim *(list all entries, separate with a comma)*

Residence Address of Deceased Insured at Death *(street address, city, state, ZIP)*

Full Name of Person Signing this Form *(please print)*

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to the deceased ("Providers") to disclose Insured's entire medical record and any other protected health information concerning the Insured to Globe Life Insurance Company of New York (GLNY) and its agents, employees, and service providers. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.
By my signature below, I acknowledge that any agreements I have made to restrict the Insured's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that GLNY may: (i) underwrite the application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (ii) obtain reinsurance; (iii) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (iv) administer coverage; and/or (v) conduct other legally permissible activities that relate to any coverage with GLNY.

This authorization shall remain in force for 24 months following the date of my signature below, and 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 sending a written request for revocation to GLNY to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of Insured's Providers has relied on this Authorization, and that, to the extent that GLNY has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent GLNY from completing their review of policy claims. Such revocation shall not apply to any use or disclosure of the protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that Insured's Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if Irefuse to sign this authorization to release Insured's complete medical record, GLNY may not be able to process my application, or if coverage has been issued, may not be able to process policy claims.

I acknowledge that I have received a copy of this authorization.

Name and address to whom this information will be sent:

Globe Life Insurance Company of New York | Life Claims Department
PO Box 8076 | McKinney, TX 75070

IMPORTANT (Please select one of the statements below):

- ☐ **I am a beneficiary. Please provide relationship to the Insured (Required):** _____
- ☐ **I am a legal guardian, power of attorney designee, conservator and have attached a copy of the document granting authority.**
- ☐ **I am the Administrator / Executor of the Estate and have attached court ordered Letters of Testamentary, Executor of Estate documents, or other legal documentation.**
- ☐ **There is no court appointed Administrator/Executor and I am the Next of Kin. Please provide relationship to the Insured (Required):** _____

New York Fraud Warning: 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 Signed**

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Statement of Medical Provider

This statement should be completed by the Deceased's Medical Provider.

Before completing and signing this claim form, please carefully read the Claim Fraud Warning (pp. 8–9) for the state of New York and for the state where you reside. Please attach additional pages if necessary.

Deceased's Full Name *(please print)*	Date of Birth / /	Age

Medical Provider's Name *(please print)*	Phone Number	Fax Number

Medical Provider's Address *(street address, city, state, ZIP)*

Medical History

1. Were you the deceased's treating medical provider? ☐ **No** ☐ **Yes** *(if Yes, include specialty and duration of care):*

2. When was the deceased diagnosed with the disease or impairment that resulted in death?

3. Was the deceased ever treated for drug or alcohol abuse? ☐ **No** ☐ **Yes** *(if Yes, provide treatment duration and location(s) details):*

4. Did the deceased have any disabilities? ☐ **No** ☐ **Yes** *(if Yes, specify nature and duration):*

5. Did the deceased suffer from any other significant medical conditions or impairment(s)?
☐ **No** ☐ **Yes**
(if Yes, specify condition(s) and duration):

Disease/Impairment	*Duration*

6. Was the deceased hospitalized in the past three years? ☐ **No** ☐ **Yes** *(if Yes, provide hospital(s) name, address, and treatment duration):*

7. List all health practitioners who treated the deceased in the past five years (name, specialty, and address):

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Signature of Medical Provider **Date Signed**

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Claim Fraud Warnings

Before completing and signing this claim form, please carefully read the Claim Fraud Warning for New York and the state where you reside.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, Louisiana, Massachusetts, Rhode Island and West Virginia: 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.

California: For your protection, California law requires the following to appear on this form: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A 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.

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

District of Columbia: 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.

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.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

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

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Claim Fraud Warnings Continued

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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 NH RSA § 638:20.

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 Mexico: 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.

New York: 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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.