

Combined Life Insurance Company of New York

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-951-6206 • Fax 312-351-6930

The Health and Wellness Benefit

After your coverage has been in force for the applicable waiting period **as stated in your policy**, Combined Life Insurance Company of New York will pay a Health and Wellness Benefit for any one of the health screening tests or procedures shown below. This benefit will only be paid once in a policy year for each person covered. The actual benefit amount you will receive is stated in your Schedule of Benefits that accompanies your Policy. To file a claim for a service provided, you may use our online claim center at www.combinedinsurance.com/claims or fax this completed form to 1-312-351-6930. **For Mammography: be sure to include the itemized bill of the procedure from the provider who performed the screening.** Note: In some situations, additional information may be requested.

FIRST NAME	LAST NAME	M.I.
ADDRESS		
CITY	STATE	ZIP
E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file)		PHONE NUMBER
POLICY NUMBER(S)		

Please enter the date of service. (MM/DD/YYYY)

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Please check all screenings performed. Refer to your policy for specific details about qualifying screenings.

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|---|---|--|
| <input type="checkbox"/> Blood test for triglycerides | <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Pap smear |
| <input type="checkbox"/> Bone marrow aspiration or biopsy | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> PSA (blood test for prostate cancer) |
| <input type="checkbox"/> Breast ultrasound | <input type="checkbox"/> Fasting blood glucose test | <input type="checkbox"/> Serum cholesterol test |
| <input type="checkbox"/> CA 15-3 (blood test for breast cancer) | <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> Stress test on a bicycle or treadmill |
| <input type="checkbox"/> CA125 (blood test for ovarian cancer) | <input type="checkbox"/> Hemoccult stool analysis | <input type="checkbox"/> Thermography |
| <input type="checkbox"/> CEA (blood test for colon cancer) | <input type="checkbox"/> Mammography | |
- Other

If you had a Health or Wellness Screening at your workplace, please complete below:

PLACE OF SERVICE	SERVICE PERFORMED BY
EMPLOYER	EMPLOYER HUMAN RESOURCE SIGNATURE

Statements made by you on this claim form must be true and complete. You must sign and date this claim form on the signature line provided on the Fraud Warning page. ***If you do not sign this claim form, we cannot accept your claim submission.***

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CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Life Insurance Company of New York ("Combined") of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at <https://my.combinedinsurance.com> or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-800-951-6206, Monday through Friday between 7:30 am and 6:00 pm CST or go to www.combinedinsurance.com/us-en/contact-us to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

