NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

SEVENTH AMENDMENT TO 11 NYCRR 65-3
(INSURANCE REGULATION 68-C)
REGULATIONS IMPLEMENTING THE COMPREHENSIVE MOTOR VEHICLE INSURANCE
REPARATIONS ACT

SIXTEENTH AMENDMENT TO 11 NYCRR 216
(INSURANCE REGULATION 64)
UNFAIR CLAIMS SETTLEMENT PRACTICES AND CLAIM COST CONTROL MEASURES

I, Maria T. Vullo, Superintendent of Financial Services, pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Section 301 of the Insurance Law, do hereby promulgate the following amendments to Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, to take effect upon publication in the State Register, to read as follows:

(MATTER IN BRACKETS IS DELETED; NEW MATTER IS UNDERLINED)

Section 65-3 is amended as follows:

NYS Form NF-10 to Appendix 13 is repealed and a new NYS Form NF-10 to Appendix 13 is added.

Section 216.6(h) is amended as follows:

(h) Any notice rejecting any element of a claim involving personal property insurance shall contain the identity and the claims processing address of the insurer, the insured's policy number, the claim number, and the following statement prominently set forth:

“Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you may write to or visit the Consumer Assistance Unit, Financial Frauds and Consumer Protection Division, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; [163B Mineola Boulevard, Mineola, NY 11501] 1399 Franklin Avenue, Garden City, NY 11530; or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.”

Section 216.7(d)(3) is amended as follows:

(3) Any letter of explanation or rejection of any element of a claim shall contain the identity and claims processing address of the insurer, the insured's policy number, the claim number and the following statement, prominently set forth:

“Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at
http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you may write to or visit the Consumer Assistance Unit, Financial Frauds and Consumer Protection Division, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; [163B Mineola Boulevard, Mineola, NY 11501] 1399 Franklin Avenue, Garden City, NY 11530; or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.”
NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send two copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

<table>
<thead>
<tr>
<th>A. POLICYHOLDER</th>
<th>B. POLICY NUMBER</th>
<th>C. DATE OF ACCIDENT</th>
<th>D. INJURED PERSON</th>
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<tbody>
<tr>
<td>E. CLAIM NUMBER</td>
<td>F. APPLICANT FOR BENEFITS (Name and address)</td>
<td>G. AS ASSIGNEE</td>
<td>YES</td>
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TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

1. Your entire claim is denied as follows:
   - Loss of Earnings $ D. Interest $
   - Health Service Benefits $ E. Attorney's Fee $
   - Other Necessary Expenses $ F. Death Benefit $

2. A portion of your claim is denied as follows:
   - Loss of Earnings $ D. Interest $
   - Health Service Benefits $ E. Attorney's Fee $
   - Other Necessary Expenses $ F. Death Benefit $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

- Policy issues
- Loss of earnings benefits denied
- Other reasonable and necessary expenses denied
- Health service benefits denied

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

- Provider of Health Service (Name, Address and Zip Code)
- Period of bill - treatment dates
- Date of bill
- Amount of bill $ 
- Type of service rendered
- Date bill received by insurer
- Amount paid by insurer $ 
- Date final verification received
- Amount in dispute $ 

33. State reason for denial, fully and explicitly (attach extra sheets if needed):

DATE Name and Title of Representative of Insurer Telephone No. & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable Telephone No. & Ext.

NYS FORM NF-10 (Rev 1/2017)
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IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you may write to or visit the Consumer Assistance Unit, Financial Frauds and Consumer Protection Division, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12255; 1399 Franklin Avenue, Garden City, NY 11530, or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Department of Financial Services will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Department of Financial Services at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. You may submit this dispute to arbitration. If you wish to submit this claim to arbitration, then mail or e-mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable by check, money order, or credit card to the American Arbitration Association (AAA) to:

   AMERICAN ARBITRATION ASSOCIATION (AAA)
   NEW YORK INSURANCE CASE MANAGEMENT CENTER
   120 BROADWAY
   NEW YORK, NEW YORK 10271
   nyicmc.filingsubmissions@adr.org

Please contact the American Arbitration Association's customer service department at (917) 438-1660 with any questions about case filing.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and regulations promulgated thereunder.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of earnings: Date claim made: ______________________ Gross earnings per month $ ______________________

Period of dispute: From ___________ Through ___________ Amount claimed: $ ______________________

Health Services: (Attach bills in dispute and list each one separately)

<table>
<thead>
<tr>
<th>Name of Provider(s)</th>
<th>Date of Service</th>
<th>Amount of Bill</th>
<th>Amount in Dispute</th>
<th>Date Claim Mailed</th>
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Other Necessary Expenses: (Attach bills in dispute and list each one separately)

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<tr>
<th>Type of Expenses Claimed</th>
<th>Amount Claimed</th>
<th>Date Incurred</th>
<th>Date Claim Mailed</th>
<th>Amount in Dispute</th>
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Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for special expedited arbitration if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.
3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>NAME OF LAW FIRM, IF ANY</th>
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<th>ARE YOU AN ATTORNEY?</th>
<th>DATE</th>
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<td>YES ☐</td>
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<tr>
<td>NO ☐</td>
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SIGNATURE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (646-205-7800) located at 100 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.
I, Maria T. Vullo, Superintendent of Financial Services, do hereby certify that the foregoing is the Seventh Amendment to Part 65-3 and Sixteenth Amendment to Part 216 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulations 68-C and 64) signed by me on January 10, 2017 pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Section 301 of the Insurance Law, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed rule was published in the State Register on November 23, 2016. No other publication or prior notice is required by statute.

Maria T. Vullo
Superintendent of Financial Services

Date: January 10, 2017