NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY
ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NY 12243-0001

David A. Paterson
Governor

David A. Hansell
Commissioner

Informational Letter

Section 1

Transmittal:	09-INF-13
To:	Local District Commissioners
Issuing Division/Office:	Center for Employment and Economic Supports
Date:	June 12, 2009
Subject:	Revised LDSS-1410: "Life Insurance Information Request – Prudential and MetLife"
Suggested Distribution:	Temporary Assistance Staff Food Stamp Benefits Staff Medicaid Directors CAP Coordinators Employment Coordinators WMS Coordinators Staff Development Coordinators
Contact Person(s):	Forms Questions: Kelly Whitney @ 1-800-343-8859, ext. 3-7991 Policy Questions: TA Bureau @ 1-800-343-8859, ext. 4-9344
Attachments:	LDSS-1410: "Life Insurance Information Request – Prudential and MetLife" LDSS 1412: "Life Insurance Adjustment Request"
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
94 INF-37					

Section 2

I. Purpose

The purpose of this Informational Letter (INF) is to inform local departments of social services (local districts) that the Prudential Insurance Company mailing address has changed.

II. Background

The LDSS-1410 was developed in response to the needs of local districts for a standard form when making inquiries on the value of life insurance policies underwritten by Prudential and Metropolitan insurance companies held by both applicants and recipients.

III. Program Implications

The LDSS-1410 is designed to be mailed directly to the appropriate insurance company at the time of application or whenever the value of a life insurance policy must be verified. The reverse of the LDSS-1410 references a form - LDSS-1412 - which is being made available with this INF for your convenience.

IV. Forms Ordering Information

- The revised LDSS-1410: *"Life Insurance Information and Request – Prudential and MetLife"* is **not** State-printed but is available to local districts in PDF format or as master camera ready copy. The procedures for ordering PDFs or master camera ready copies are listed below.

- Upon the release of this INF, all previous versions of the *"Life Insurance Information and Request – Prudential and MetLife"* **must immediately be destroyed** and replaced with the revised 3/09 version.

- The LDSS-1410, as well as the LDSS-1412, have also been posted on the OTDA Intranet website at http://otda.state.nyenet/ldss_eforms/default.htm and are available for downloading by local districts for reproduction locally.

- Any future requests for printed copies of the LDSS-1410 should be submitted on an OTDA-876 "Request For Forms or Publications" and sent to:

Office of Temporary and Disability Assistance
BMS Document Services and Operational Support
P.O. Box 1990
Albany, New York 12201

OR

Download and complete OTDA-876 Form (http://otda.state.nyenet/psqi/eforms/OTDA-876-Req_For_Documents_or_Publications.dot) and e-mail form to gg7359@dfa.state.ny.us.

Questions concerning ordering forms should be directed to BMS Document Services at 1-800-343-8859, ext. 4-9522.

- For a complete list of available forms, please refer to the OTDA Intranet site: http://otda.state.nyenet/ldss_eforms/default.htm .

Issued By
Name: Russell Sykes
Title: Deputy Commissioner
Division/Office: Center for Employment and Economic Supports

LDSS-1410 (Rev. 3/09)

LIFE INSURANCE INFORMATION REQUEST – PRUDENTIAL AND METLIFE

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

TO:

DATE _____

INSURANCE COMPANY: _____ COUNTY: _____

DEPARTMENT: _____ ADDRESS: _____

ADDRESS: _____ CITY: _____

(Addresses of companies appear on reverse side)

Sir or Madam:

The insured is unable to furnish the information requested below. We are authorized to secure this information from you.

_____
CASE NAME

_____
ADDRESS

CITY: _____

CASE NUMBER: _____

_____
NAME AND TITLE OF SOCIAL SERVICES REPRESENTATIVE

Note: *Always furnish policy numbers including any prefix or suffix.*	POLICY NO. PREF. SUFF.	POLICY NO. PREF. SUFF.	POLICY NO. PREF. SUFF.
First Name of Insured			
Kind of Policy			
Face Amount of Policy			
Date Issued			
Age of Issue			
Amount of Premium			
Status of Policy (if lapsed, date of lapse and non-forfeiture value, if any.)			
Policy Liens or Loans			
Present Net Cash Surrender Value including Accumulated Dividends			

OTHER INFORMATION *(Specify)*

TO THE SOCIAL SERVICES AGENCY

The information requested is provided according to current records. If your state laws or regulations require any change or adjustment to qualify the insured for Temporary Assistance, please complete the reverse side of this form and sign it.

INSTRUCTIONS FOR ADJUSTMENT FOR THE SOCIAL SERVICES AGENCY

If the policies for this individual, or family, are to be adjusted, use Form DSS-1412 (INS-PM-2). If there is more than one policy, and if more than one adjustment is necessary, complete a separate form for each policy unless requesting change forms (item 4, Form DSS-1412 (INS-PM-2).

METLIFE POLICIES:

Send completed Form DSS-1412 (INS-PM-2) TO:
(See Below for appropriate name*) Division

MetLife
P.O. Box 336
Warwick, RI 02887-0336

***Type of Transaction**	**Name of Division**
Cash Surrender	Cash Correspondence (also submit the policy)
Lapsed for Reduced Paid Up Insurance	Cash Correspondence (do not submit the policy)
Policy Loan	Loan Correspondence (do not submit the policy)
Change of Plan or Amount	Change

PRUDENTIAL POLICIES:

Send completed Form DSS-1412 (INS-PM-2) for all transactions to:

For: All counties in New York State

To: Prudential Financial
PO Box 7390
Philadelphia, PA 19176

Send the policy together with the Form in all instances except requests for policy loans.

LDSS-1412 (10/69) *(INS-PM-2)*

LIFE INSURANCE ADJUSTMENT REQUEST

State of New York — Office of Temporary and Disability Assistance

To _____ (herein after called the "Company") *(Name of Insurance Company)*	**DATE**

We have checked the box indicating the adjustments needed in this case. Please send all correspondence to:

_____
(Full Name of Caseworker)

Address: _____

Prefix:	Policy Number:	Suffix:	Name of Insured:

☐ 1. *Application for The Cash Surrender Value* of the above-numbered policy is hereby made by the undersigned. Request is also made that the designated beneficiary or beneficiaries be removed and the policy be made payable to the executors or administrators of the Insured, or to the owner if other than the insured, except that such request shall not apply in the case of a policy subject to the laws of Canada. It is understood, however, that any such change of beneficiary shall be void and that this application for cash surrender shall be of no effect if this application is withdrawn before issuance of the check, or if the Insured dies before the delivery or tender of the check.

Each of the undersigned executing this form certifies to the Company that no proceedings in bankruptcy of insolvency, voluntary or involuntary, have ever been instituted by or against any or either of them, except as follows:

The Company is hereby authorized to make payment by a check drawn to the order of the person or persons who have the right to receive the cash surrender value.

Each of the undersigned executing this form represents to the aforementioned Company that he (or she) has attained to majority according to the laws of the State in which he (or she) resides or that he (or she) is empowered by law to execute this form even though majority has not been attained.

WITNESS TO SIGNATURE OF INSURED *(Caseworker)*	**SIGNATURE OF INSURED**
WITNESS TO SIGNATURE OF OWNER *(Caseworker)*	**SIGNATURE OF OWNER *(If other than Insured)***

The Policy Must Be Returned With This Application To The Insurance Company

PREFIX	**POLICY NUMBER**	**SUFFIX**	**NAME OF INSURED**

☐ 2. *Application For Reduced Paid-Up Insurance.* The undersigned elect(s) reduced paid-up insurance in accordance with the non-forfeiture provisions of the above-numbered policy.

The undersigned agree(s) that any assignment of record applicable to said Policy shall automatically become an assignment of the reduced paid-up insurance.

Each of the undersigned executing this form represents to the aforementioned Company that he (or she) has attained to majority according to the laws of the State in which he (or she) resides or that he (or she) is empowered by law to execute this form even though majority has not been attained.

WITNESSED BY *(Caseworker)*	**SIGNATURE OF INSURED OR OWNER *(If Other Than Insured)***

For Prudential Policies: The policy must be returned with this application.
For Metropolitan Policies: Submission of the policy with this application is not required.

LDSS-1412 (10/69) *(INS-PM-2)*

PREFIX	POLICY NUMBER	SUFFIX	NAME OF INSURED

☐ 3. *Application for Policy Loan*. The undersigned hereby applies to the Insurance Company for a policy loan in an amount sufficient to reduce the present loan value including the value of any dividends left with the Company to $_____. The undersigned hereby assigns to the Company the said policy and all dividends and benefits now due or which may hereafter become due or be allowed by the Company on said Policy, to secure the repayment of said loan and the interest thereon. The undersigned agrees that said loan shall bear interest at the rate specified in said policy and if such interest is not paid when due, it shall be added to the said loan and bear interest at the same rate. If said loan is granted, any pre-existing loan indebtedness under a previous loan shall be deducted by the Company from the amount of this loan and any certificate of such previous loan shall be cancelled upon the records of the Company. The undersigned further agrees that, if any due premiums for this policy have not been paid on or before the date of this application, the Company may deduct from the amount of this loan an amount which will be applied in payment of such due premiums. A detailed loan statement will be furnished.

WITNESSED BY *(Caseworker)*	SIGNATURE OF INSURED OR OWNER *(If Other Than Insured)*

Submission of the policy with this application is not required by either Company.

	Name of Insured

☐ 4. *Request for Change Forms*. The Company is hereby requested to furnish the caseworker with the appropriate forms for a policy change or conversion as indicated below:

PREFIX	POLICY NUMBER	SUFFIX	FROM	TO

It is understood that necessary forms will be sent to the caseworker, and that it will be necessary to submit the policy(ies) to the Company with the forms when completed.