



ACCELERATED BENEFITS STATEMENT

Please print or type all information. Signatures should be in blue or black ink.

POLICYHOLDER/EMPLOYER'S STATEMENT			
Name and Address of Policyholder/Employer:			Policy Number:
Employee/Applicant's Occupation or Job Title:		Employee/Applicant's First Date of Full Time Employment:	
Employee/Applicant's Effective Date of Insurance:		Employee/Applicant's Amount of Insurance:	
Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Other, please specify: If Retired or Terminated, please give date:			
Date Employee/Applicant last worked:	Last Month Premium was Paid:	Employee/Applicant's Annual Salary:	
Form completed by (print): Signature:	Title:	Telephone Number:	Date:
EMPLOYEE/APPLICANT'S STATEMENT			
Name of Employee/Applicant:		Date of Birth:	Social Security Number:
Employee/Applicant's Address:			
Is there currently an Irrevocable Beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please have beneficiary sign here authorizing the Accelerated Benefit payment. Beneficiary's Signature: Please print Beneficiary's name:			
Are there any assignments of this insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
Has any creditor required that you exercise this option? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has any government agency required that you exercise this option as a condition for obtaining or retaining a government benefit or entitlement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Amount of Accelerated Benefit Requested:		For Policies issued in Mississippi Only: Select Payment option: <input type="checkbox"/> Lump Sum <input type="checkbox"/> Installments (specify amount and duration)	
Please attach the Attending Physician's Statement for Accelerated Death Benefits to this application.			
AUTHORIZATION			
I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that payment of Accelerated Benefits is based on my application for Accelerated Benefits.			
I authorize any Physician, health care provider, hospital, insurance company, reinsurance company and any employer to release to the Insurance Company or its reinsurers any and all medical information about me. I further authorize the Insurance Company to release this information to its reinsurers and to other insurance companies to which I have applied for coverage or benefits.			
I understand that I may receive a copy of this authorization upon request, and I agree that a photocopy or electronic version of this authorization is as valid as the original.			
I know and understand that:			
<ol style="list-style-type: none"> 1. It is a crime to willingly omit or provide false information on this form. 2. According to Section 20 of the Public Health Law, no health care facility can require any person to accelerate payment of a death benefit to satisfy any condition of admission to said facility or for providing care in that facility. 3. That if my benefit request is approved, my insurance amount will be reduced or cancelled. 			
I have completed this form voluntarily, without coercion from a third party.			
Signature of Employee/Applicant or Legal Representative:			Date:
Fraud notice: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.			



DISCLOSURE STATEMENT

Name of Employee/Applicant:	Policy Number:	Date:
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Policyholder/Employer's Name

This form is to notify you of the effect an Accelerated Benefit payment may have on your coverage.

Please Note: Accelerated Benefits may be taxable and may affect your eligibility for Medicaid or other government benefits and entitlements. You should consult a personal tax or legal advisor regarding the taxation of Accelerated Benefits or its affect on entitlement to government benefits.

Accelerated Benefits may be paid only once during your lifetime. If you die before the Accelerated Benefit is paid, then your life insurance benefits will be paid in accordance with the Benefit Payment And Beneficiary provisions.

An Accelerated Benefit is not payable if:

1. You have assigned all or part of your Life Insurance, unless you provide us with written consent from the assignee.
2. All or part of your Life Insurance is payable to your children, or your spouse or former spouse under a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
3. You are married and live in a community property state, unless you provide us with written consent from your spouse. You have previously received an Accelerated Benefit.

Checklist

<input type="checkbox"/> Accelerated Benefits Statement
<input type="checkbox"/> Attending Physician's Statement
<input type="checkbox"/> Any documents concerning the right of any person to act as the employee/applicant's agent

This section is to be completed by the Insurance Company.

Attached is a check for the Accelerated Benefit available under this policy. The remaining amount of your group term Life Insurance is shown below:

Original Term Life Amount:	\$ _____
Less Accelerated Benefit Payment:	\$ _____
Remaining Term Life Amount:	\$ _____

Signature:	Date:
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Print Name:	Title:
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**ATTENDING PHYSICIAN'S STATEMENT
 FOR ACCELERATED DEATH BENEFITS**

Please print or type all information. Signatures should be in blue or black ink

PATIENT IDENTIFICATION		
Patient/Employee/Applicant's Name:		Patient ID Number:
Social Security Number:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer's Name and Address:		
PHYSICIAN'S STATEMENT		
Nature and cause of patient's primary diagnosis or condition:		
Diagnosis or ICD Codes:		
What is the life expectancy of the patient based on the current diagnosis and condition?		
Please advise the date the life expectancy determination was made:		
When did the symptoms first appear or the injury occur?		
Has patient ever had the same or any similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?		
Date of first visit for this condition:	Date of last visit:	Date Total Disability began
Objective findings including results of current x-rays, EKG, or other special tests:		
Patient's Condition: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Regressed <input type="checkbox"/> Unchanged <input type="checkbox"/> Ambulatory <input type="checkbox"/> Hospital Confined <input type="checkbox"/> Home Confined <input type="checkbox"/> Bed Confined		Is the patient able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are the patient's limitations?
Is the patient capable of handling his/her own affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Visit Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> As Needed		
Name and address of any referring physician:		
Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name and address of the facility.		
Dates of hospital confinement:		
Attending Physician Name (Print):		Telephone Number:
Address:		
Signature of Attending Physician:	Degree/Specialty:	Date:

**Thank you for your assistance.
 See attached Fraud Warnings**



FRAUD WARNINGS

Alaska, Arizona, Delaware, Hawaii, Idaho, Indiana, Louisiana, Maine, Minnesota, New Hampshire, New York, Pennsylvania, Tennessee - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may be subject such person to criminal and substantial civil penalties.

Arkansas - 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, CA law requires the following to appear on the claim form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Kentucky - Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance 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.

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.

Oklahoma - WARNING: Any person who knowingly and with intent to injure, defraud any 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.

Texas - Any person who knowingly presents a false or fraudulent claim may be subject to fines and confinement in state prison.