MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

INITIAL CLAIM FORM FOR ACCELERATED BENEFITS

This form should be prepared by the employee, his attending physician and employer. Immediately after the diagnosis of a terminal illness for which a claim is being submitted. Forward completed claim forms to **Medico Life and Health Insurance Company.** Attach a separate statement if space provided on the form is inadequate for complete answers. By furnishing this claim form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

Insured's Statement

Name of Employer _____ Group # _____
Name of Insured _____ Date of Birth _____
Social Security No. _____
Address of Insured _____ Sex _____
When did terminal illness begin _____ 20_____
Describe nature of terminal illness _____
_____ Name of attending physician
If confined in hospital, give name and address of hospital _____
_____
Admitted (give dates and times) _____ Discharged _____
Do you understand that any payment of the accelerated benefit will reduce the death benefit payable under this policy?
❑ Yes ❑ No
Are any benefits under this group policy assigned, or payable as part of a divorce settlement?
❑ Yes ❑ No

The above Statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish to the Insurance Company providing this form, or their representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions treatments or benefits, and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

_____ _____
Signature of Insured *Date*

Employer's Statement

Name of Insured _____ Date Hired _____
Social Security # _____ Job Title _____
Policy Effective Date _____ Amount of basic coverage _____
Last date and times worked? _____
Date & time returned to work _____
If not back to work, do you expect Insured to return to work? _____
Do you recommend payment of this claim? ❑ Yes ❑ No
REMARKS: _____
_____

Employer _____ Group Number _____
Mailing Address _____ Telephone (_____) _____
_____

By _____ Title _____ Dated _____ 20_____
Authorized Company Representative

The receipt of a Living Benefit MAY be taxable income to you, seek advice from your PERSONAL TAX ADVISOR.

Attending Physician's Statement
Accelerated Benefit Claim Form

Patient's Name _____

Diagnosis

Nature of sickness or injury (describe complications, if any) _____

Prognosis _____

When did symptoms first appear or accident happen? _____

When did patient first consult you for this condition? _____

Is condition due to any intentionally self-inflicted injury or suicide attempt? _____

Services

List Non-Surgical Treatments and Dates _____

List Surgical Procedures and Dates _____

Physician's Statement

Is patient still under your care for this condition? ❑ Yes ❑ No
Do you consider this condition terminal? ❑ Yes ❑ No
In your medical judgment, how long is the life expectancy of this patient? _____

Name of Physician (Type or Print) _____
Signature of Physician _____ Date_____
Address_____
City _____ State_____ Zip_____ Telephone_____