



Accelerated Benefit Request

Policy Number _____	List all other policies: _____ _____
Amount of Benefit _____	
Advance Requested \$ _____	

Statement of Insured

Name (Please Print) _____		Phone No. _____	
Most Recent Hospitalization		Name of Hospital	
From _____	Through _____		
Address of Hospital _____	City _____	State _____	ZIP _____

Name and Address of your Doctors

Date First Treated _____	Date Last Seen _____
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What is your understanding of your condition (health)? Please describe.

Signature

I certify that all the above statements are complete and accurate to the best of my knowledge.

Signature of Insured _____	Date _____	Social Security Number _____
Signature of Guardian (If Insured is a minor) _____		Duly sworn before me, a Notary Public, on this day _____ of _____, _____.
Signature of Beneficiary (If Irrevocable) _____		
Address _____		
Witness _____	Date _____	

Part A

To be Completed by Patient (Insured)

Name of patient _____ Date of Birth _____
Month Day Year

Authorization to Release Information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signature (Patient or Parent if Minor)

Date

Part B

Attending Physician Statement

To Physician: The patient is requesting an advance benefit payment on life insurance. Your statement is needed to determine the patient's eligibility. Please attach an additional sheet of paper if you need more space to continue your answers.

1. History

- (a) When did symptoms first appear or accident happen?..... Mo. _____ Day _____ Yr. _____
- (b) Date patient informed of diagnosis? Mo. _____ Day _____ Yr. _____
- (c) Has patient ever had same or similar condition?..... Yes No
If "Yes", state when and describe. _____

2. Diagnosis and Prognosis

- (a) Is patient's condition terminal? Yes No
- (b) If "Yes", within _____ months
- (c) Diagnosis (including any complications) _____

- (d) Subjective symptoms _____

- (e) Objective findings (including current X-rays, EKG's Laboratory Data and any clinical findings) _____

- (f) In your opinion, has this affected the mental capacity of the patient? Yes No
- (g) Other comments _____

3. Dates of Treatment

- (a) Date of first visit Mo. _____ Day _____ Yr. _____
- (b) Date of last visit Mo. _____ Day _____ Yr. _____
- (c) Frequency..... Weekly Monthly Other (specify) _____

4. Plan of Treatment (Including surgery and medications prescribed, if any)

5. Progress

- (a) Has patient Recovered? Improved? Unchanged? Retrogressed?
- (b) Is patient Ambulatory? House confined? Bed confined? Hospital confined?
- (c) Has patient been hospital confined? Yes No If yes, confined from _____ through _____
Name and address of Hospital _____

Print Physician's Name	Degree	Specialty	Telephone
Street Address	City	State or Province	ZIP Code

I certify that the above information is complete and accurate to the best of my knowledge.

Physician's Signature _____ Date _____