MEDICO®
INSURANCE COMPANY

Life Insurance
Claims Division

Accelerated Benefit Request

Policy Number _____

Amount of Benefit _____

Advance Requested $ _____

List all other policies:

_____

_____

Statement of Insured

Name (Please Print) | Phone No.

Most Recent Hospitalization
From Through

Name of Hospital

Address of Hospital | City | State | ZIP

Name and Address of your Doctors

Date First Treated | Date Last Seen

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)

Signature of Beneficiary (If Irrevocable)

Address

Witness Date

Duly sworn before me, a Notary Public, on this day
_____ of _____ , _____.

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 _____