USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416

Accelerated Death Benefits Statement of Claim

Please type or print in blue or black ink.

(To Avoid Delay Please Answer All Questions)

Employer's Statement

1. Employee's Name	2. Employee's Social Security No.	
3. Group Policy Number	4. Amount of Life Insurance	5. Employee's Date of Hire
6. Employee's Eff. Date of Insurance	7. Employee's Last Date Worked	8. Reason Employee Stopped Work
9. Employee's Occupation at Time Stopped Work	10. Do You Expect Employee to Return to Work ❑ Yes ❑ No	
Employer Name	Date	
Signature	Title	
Name (Please print or Type)	Telephone ( )	
Street Address	City, State, ZIP	

Employee's Statement

1. Full Name (Last, First, Middle)			2. Benefit Amount Requested ❑ Maximum Amount Available ❑ $ _____	
3. Date of Birth	4. Sex ❑ Male ❑ Female	5. Height	6. Weight	7. Date Symptoms Appeared
8. Describe nature of illness or injury				
9. Date of First Treatment	Treated by: Doctor _____ Name Address City, State, ZIP			

10. Have You Made An Absolute Assignment Of This Coverage?
❑ Yes ❑ No If Yes, to whom: Name _____
Address _____

11. Is This Insurance To Be Paid To Your Children/Former Spouse Under A Court Ordered Agreement?
❑ Yes ❑ No

12. Have You Designated Anyone as an Irrevocable Beneficiary of these Proceeds?
❑ Yes ❑ No **If Yes, please have Beneficiary complete the Irrevocable Beneficiary Consent**

IRREVOCABLE BENEFICIARY CONSENT

Name	Social Security No.	Date of Birth
Address (include Street, City, State and ZIP)	Telephone ( )	

I, the undersigned irrevocable beneficiary of the above described life insurance benefits, do hereby consent to the payment of the Accelerated Death Benefits and understand this will result in a lesser amount of life insurance benefits which will be payable to me at the time of the insured's death. I further agree to release and hold harmless USAble Life from any and all causes of action which I may now have, or which may arise in the future, resulting or related to the payment of the Accelerated Death Benefits.

Date	Signature of Irrevocable Beneficiary	
Date	Witness **(CANNOT Be the Employee)**	Signature
Address (include Street, City, State and ZIP)		Telephone ( )

Authorization to Obtain Information

In signing below, I represent that the statements and answers given are true, complete and correctly recorded. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge I have a right to a copy of this authorization upon request.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date	Signature of Claimant/Employee

Attending Physician's Statement

Name of Patient	Date of Birth

1. History
   a. When did symptoms first appear? Date: _____
   b. Has patient ever had same or similar condition? ❑ Yes ❑ No
      If so, when? Date _____

2. Diagnosis

	ICD-9 (Must have to Process)
_____	_____
_____	_____
_____	_____

3. Objective Findings. (Please specify and include current radiology, EKG and laboratory data.)

_____
_____
_____

4. Dates of Treatment

a. Date of first visit _____
b. Date of last visit _____
c. Frequency of visits _____

5. Nature of Treatment (Include surgery and medications.)

_____
_____
_____
_____
_____

6. Progress
   a. Has patient (check one) ❑ Recovered ❑ Improved ❑ Unchanged ❑ Worsened
   b. Is patient (check one) ❑ Ambulatory ❑ House Confined ❑ Bed Confined

7. Prognosis (Please be specific)

_____
_____
_____
_____
_____
_____

8. Remarks

_____
_____
_____
_____

9. Physician's Signature		Date
Physician's Name (Please Print/Type)	Degree	Telephone ( )
Address (Include Street, City, State and ZIP)		Fax ( )

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FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

Retain for your records.