



### 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 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) _____	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 \_\_\_\_\_