USAble Life

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

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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USAble Life

AUTHORIZATION | To Disclose, Obtain and Use Personal Information

Read and sign below.

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

Signature

Sign and date this form.

I have executed this authorization intending that it will be effective on and after:

Date
•

Signature
•

Printed name
•

Return original with your claim and retain a copy of this authorization and claim form for your records.

USABLE® LIFE | FRAUD NOTICE

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Please see below for special notices required by state law.

AL Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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

CA Residents Only: Any person who knowingly presents a 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.

CO Residents Only: 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.

DE, ID, IN, OK Residents Only: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC Residents Only: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KS Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

ME and TN Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

MD, RI, TX Residents Only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH Residents Only: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ Residents Only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OH Residents Only: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OR Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VA and WA Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE