



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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Maximum Amount Available <input type="checkbox"/> \$ _____	
3. Date of Birth	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, to whom: Name _____ Address _____				
11. Is This Insurance To Be Paid To Your Children/Former Spouse Under A Court Ordered Agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No				
12. Have You Designated Anyone as an Irrevocable Beneficiary of these Proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worsened b. Is patient (check one) <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> 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 ()
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.		



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.

AK Residents Only: A 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.

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.

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 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: 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.

MD 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.

ME 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.

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 and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

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.

TN Residents Only: 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 a denial of insurance benefits in accordance with applicable state law.

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.

Date

Signature