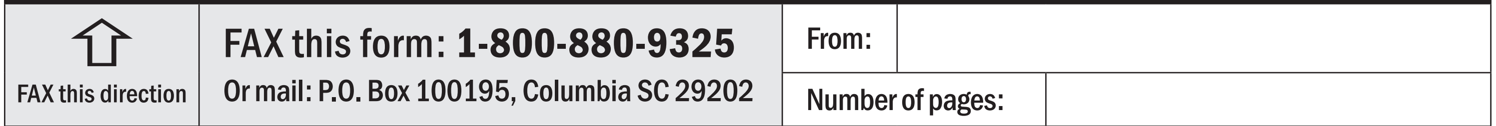

Accelerated Benefit Claim Form

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia SC 29202	From:
		Number of pages:

Use this form when filing for an Accelerated Death Benefit. Please make sure that all written responses are legible.

- If your name has changed, attach a copy of your driver's license or other legal documentation.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Social Security number is indicated by SSN.

Section 1 – Claimant statement (completed by policy owner)

General Notice: In order for the owner of the policy to receive terminal illness benefits, the owner must provide proof that the insured has a terminal illness (as defined in your policy) by providing proof of loss (including any request for additional information) that is acceptable to the company. All relevant supporting information must be received by the company before a final determination of benefits can be made.

Insured's name:		Policy No(s):	
Address:	City:	State:	ZIP:
Telephone No:	DOB: ____ /____ /______	SSN:	
Driver's License #:			

Is there an irrevocable beneficiary on this policy? ☐ Yes ☐ No

If yes, print beneficiary's name:	Beneficiary's signature:

Is there an assignment? ☐ Collateral $____ ☐ Absolute

Print assignee's name:	Assignee's signature:

When a policy is collaterally assigned, the check(s) will be issued payable to the owner and assignee.

Please describe the medical condition resulting in the accelerated benefit insured's terminal illness (as defined in your policy):

Date the insured consulted a physician for this condition: ____ /____ /______	Is the insured currently working? ☐ Yes ☐ No If not, date last worked ____ /____ /______

Claimant name:	**Claimant SSN:**

Names and addresses of all hospitals, medical facilities, doctors or practitioners, and dates consulted or received treatment in the past 10 years.

Physicians			**Physicians**		
Physician Name:			Physician Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ( )	Fax: ( )		Phone: ( )	Fax: ( )	
Dates Treated (mm/dd/yyyy):			Dates Treated (mm/dd/yyyy):		
Hospitals			**Hospitals**		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ( )	Fax: ( )		Phone: ( )	Fax: ( )	
Dates Admitted (mm/dd/yyyy):			Dates Admitted (mm/dd/yyyy):		
Dates Discharged (mm/dd/yyyy):			Dates Discharged (mm/dd/yyyy):		
Attach additional names of doctors and hospitals on a separate sheet.			**Attach additional names of doctors and hospitals on a separate sheet.**		

Claimant name:	**Claimant SSN:**

Section 2 – Terminal Illness (completed by policy owner)

The undersigned insured hereby agrees to the Accelerated Benefit Election.

Amount requested: (Check One) ☐ Maximum amount available ☐ $____________ (Write in specific amount)

Certification

Policy owner's name: ______________________________ SSN: ____________

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statement on page two of this form and that I read the statement required by the State Department of Insurance for my state. **Fraud Warning:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

There may be other means available to achieve the intended goal, including a policy loan.

Application for this benefit is voluntary and without coercion on the part of any third party.

We are prohibited from paying accelerated death benefits for a period of 5 days from the date we transmit to the owner a numerical computation and illustration of accelerating the death benefit.

Upon payment of the Accelerated Death Benefit, the death benefit available to the beneficiary will be reduced by the amount of Accelerated Death Benefit requested by you.

This form must be completed and signed by you not more than 30 days after the date of this letter.

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners or certificate holders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policyowners or certificate holders should seek assistance from a qualified tax advisor.

______________________	______________________	______________
Print Insured's Signature	Insured's signature	Date (MM/DD/YYYY)
Print Policy owner's name	Policy owner's signature (If other than the insured)	Date (MM/DD/YYYY)
Print Guardian's name (if applicable)	Guardian's signature (Please attach guardianship documents)	Date (MM/DD/YYYY)

Claimant name:	**Claimant SSN:**

Section 3 – Physician statement (completed by physician)

**** To the Physician:**
- The patient is requesting an advance benefit payment on life insurance.
- Your statement is needed to determine patient's eligibility.

Patient's Name: | DOB: ____ /____ /______

1. History

When did symptoms of this illness first appear or accident happen? ____ /____ /______

Is the patient totally and permanently disabled? ☐ Yes ☐ No
If yes, on what date did total and permanent disability begin? ____ /____ /______

Has patient ever had same or similar condition? ☐ Yes ☐ No
If yes, please state when and describe.

Names and Addresses of other treating physicians:

Physician's Name:	Physician's Name:	Physician's Name:
Address:	Address:	Address:
City: State: Zip:	City: State: Zip:	City: State: Zip:
Phone: ( )	Phone: ( )	Phone: ( )
Fax: ( )	Fax: ( )	Fax: ( )

Has patient ever smoked cigarettes or used any form of tobacco or any nicotine product? ☐ Yes ☐ No

How long has patient smoked? _____ years

How many cigarettes a day? _____

Last date patient smoked cigarettes. ____ /____ /______

Last date used any form of tobacco, nicotine delivery system or any electronic devices, nicotine substitutes, or smoking cessation product, or any electronic devise that does not contain nicotine including electronic vaporizers or cigarettes. ____ /____ /______

2. Diagnosis and Prognosis

Date patient was informed of the diagnosis. ____ /____ /______

Date initial diagnosis was made. ____ /____ /______

Is patient's condition terminal? ☐ Yes ☐ No If yes, within _____ months

Please provide complete current DIAGNOSIS and PROGNOSIS (including complications).

Subjective symptoms

Objective findings (including current X-rays, laboratory data, and any clinical findings).

Other details, findings or remarks

Is patient competent to endorse checks and direct use of proceeds? ☐ Yes ☐ No

3. Dates of Treatment

Date of first visit ____ /____ /______ | Date of last visit ____ /____ /______ | Frequency ☐ weekly ☐ monthly ☐ other ________________________

4. Nature of Treatment (including surgery and medications prescribed, if any)

Claimant name:	**Claimant SSN:**

5. Progress

Has patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed | Has patient been hospital confined? ☐ Yes ☐ No

Is patient: ☐ Ambulatory ☐ House confined ☐ Bed Confined ☐ Hospital Confined ☐ Confined in a long term care facility

Dates confined: Start ____ /____ /______ End ____ /____ /______

Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Is the insured able to perform the ADL using equipment or adaptive devices and does not require substantial assistance in order to perform the ADL. ☐ Yes ☐ No

Dates unable to perform activities of daily living from ____ /____ /______ to ____ /____ /______

Does the patient require substantial supervision due to severe cognitive impairment ? ☐ Yes ☐ No If yes, please describe cognitive impairment.

Names and addresses of hospitals and/or long term care facilities:

Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ( )			Phone: ( )		
Admission Date:	Discharge Date:		Admission Date:	Discharge Date:	

Fraud warning: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This includes Attending Physician portions of the claim form.

Physician signature	Date (MM/DD/YYYY)

Physician/group name:			Patient account number:
Physician's specialty:		Telephone:	FAX:
Address:	City:	State:	ZIP:
Tax ID or SSN:	Do you accept medical record requests by fax? ☐ Yes ☐ No		
Do you require a special authorization for release of information? ☐ **Yes** ☐ **No**	Patient Portal ☐ **Yes** ☐ **No**	Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**	
Was patient referred to you by another physician? ☐ **Yes** ☐ **No**	Authorization on file to release information to Colonial Life: ☐ **Yes** ☐ **No**		
Referring physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Tax ID or SSN:			

Authorization for The Paul Revere Life Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to The Paul Revere Life Insurance Company and its duly authorized representatives (Paul Revere).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB).

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes.

Any information Paul Revere obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information, once obtained, may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Paul Revere will not re-disclose the information unless permitted or required by those laws or as authorized by me.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), whichever is earlier, and a copy is as valid as the original. I know that I, or my authorized representative, may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time. I may revoke this authorization by sending written notice to: The Paul Revere Life Insurance Company, Claims Department, P.O. Box 100195, Columbia, SC 29202-3195.

_______________________________ Signature

_______________________________ Date signed (MM/DD/YYYY)

_______________________________ Printed name of individual subject to this disclosure

XXX-XX-__________ Last four digits of SSN

_______________________________ Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as ____________________________ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_______________________________ Printed name of legal representative

_______________________________ Signature of legal representative

_______________________________ Date signed (MM/DD/YYYY)