

## Accelerated Death Benefit for Long Term Illness Claim Form

("Long Term Illness" is also referred to as "Chronic Illness" in the state of California) The Accelerated Death Benefit for Long Term Illness Rider offers coverage if you have a condition that meets the definition of a **Long Term Illness** as outlined in the Rider. Please refer to your policy to understand the benefits provided under the Rider. If you do not meet the definition of **Long Term Illness** as described in your Rider, no benefits will be payable. After reviewing the benefits and eligibility requirements of the Rider, please complete and return the claim form below, if applicable.

### STATEMENT OF INSURED This form is to be completed by the claimant or legal representative of the claimant.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Insured's Full Name (Last, First, MI):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                   |
| Social Security Number:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Date of Birth (MM/DD/YYYY):                       |
| Phone Number:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Policy Number:                                    |
| Mailing Address (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                   |
| Legal Representative Name, if applicable:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Legal Representative Phone Number, if applicable: |
| Legal Representative Mailing Address (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                   |
| <b>All states, except California:</b> How would you like to receive your benefit payout? (Choose one)<br><input type="checkbox"/> Maximum Acceleration: Lesser of 50% or \$100,000    OR <input type="checkbox"/> Accelerate: _____% (not to exceed 50% or \$100,000)*<br><i>Your acceleration will be paid in two equal annual payments over two consecutive years up to a maximum of 25% per year (or \$50,000). Certification and medical documentation confirming the Long Term Illness is required prior to each payment.</i><br><i>* If less than the Maximum Acceleration (50% or \$100k) is elected, additional accelerations will NOT be available.</i> |                                                   |
| <b>California:</b> How would you like to receive your benefit payout? (Choose one)<br><input type="checkbox"/> Lifetime Maximum Acceleration: 50% (Lump Sum)    OR <input type="checkbox"/> 2 equal annual payments of: _____% each (not to exceed 50%)*<br><i>Your acceleration will be paid in two equal annual payments over two consecutive years up to a maximum of 25% per year. Certification and medical documentation confirming the Chronic Illness is required.</i><br><i>* If you accelerate less than the Lifetime Maximum of 50%, additional accelerations will be available until the Lifetime Maximum is exhausted.</i>                          |                                                   |
| Description of Illness or Injury:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                   |
| If injury, how and on what date did injury occur? (MM/DD/YYYY):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   |
| If illness, on what date were symptoms first noticed? (MM/DD/YYYY):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                   |
| Date of First Treatment (MM/DD/YYYY):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Date of Diagnosis (MM/DD/YYYY):                   |
| First and Last Name of Physician who provided initial consultation for the injury or illness:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |
| Physician Mailing Address (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                   |
| Name of Current Attending Physician (if different from above):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                   |
| Current Attending Physician Mailing Address (if different from above) (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |
| Name of Additional Current Attending Physician(s) (if different from above):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                   |
| Additional Current Attending Physician(s) Mailing Address (if different from above) (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| Type of Care: Please indicate level of care currently being received by the Insured (select all that apply):                                                                                                                                                                                                                |                                                         |
| <input type="checkbox"/> Nursing Home Facility <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Home Health Care <input type="checkbox"/> Homemaker Services<br><input type="checkbox"/> Adult Day Care <input type="checkbox"/> Other: (Specify) _____ |                                                         |
| Name of Care Provider:                                                                                                                                                                                                                                                                                                      | Phone Number of Care Provider:                          |
| Mailing Address of Care Provider (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                                                    |                                                         |
| Treatment/Care/Services Provided:                                                                                                                                                                                                                                                                                           |                                                         |
| Start Date of Confinement or Service (MM/DD/YYYY):                                                                                                                                                                                                                                                                          | End Date of Confinement or Service (MM/DD/YYYY):        |
| Name of Second Care Provider, if applicable:                                                                                                                                                                                                                                                                                | Phone Number of Second Care Provider, if applicable:    |
| Mailing Address of Second Care Provider, if applicable (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                              |                                                         |
| Second Treatment/Care/Services Provided, if applicable:                                                                                                                                                                                                                                                                     |                                                         |
| Start Date of Second Confinement or Service (MM/DD/YYYY):                                                                                                                                                                                                                                                                   | End Date of Second Confinement or Service (MM/DD/YYYY): |
| Name of Third Care Provider, if applicable:                                                                                                                                                                                                                                                                                 | Phone Number of Third Care Provider, if applicable:     |
| Mailing Address of Third Care Provider, if applicable (Street or P.O. Box, City, State, Zip):                                                                                                                                                                                                                               |                                                         |
| Third Treatment/Care/Services Provided, if applicable:                                                                                                                                                                                                                                                                      |                                                         |
| Start Date of Third Confinement or Service (MM/DD/YYYY):                                                                                                                                                                                                                                                                    | End Date of Third Confinement or Service (MM/DD/YYYY):  |

## Acknowledgement

Name of Person Completing Form (must be Insured or legal representative): \_\_\_\_\_

Phone Number (with area code): \_\_\_\_\_ Relationship to Insured, if applicable: \_\_\_\_\_

By signing below, I acknowledge and understand that the claims processing procedure involves the collection of personal medical information. I understand that the completion of this form, other applicable Claim Form(s), and any other form(s) required by American Fidelity or its designee(s), is not a guarantee of payment of benefits. I attest that all of the information on this form is true and complete, to the best of my knowledge and belief. I understand that American Fidelity reserves the right to require due Proof of Loss.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization to Obtain Information Including Protected Health Information

The purpose of this form is to allow American Fidelity Assurance Company, or business partners acting on behalf of American Fidelity in the administration of American Fidelity products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, American Fidelity may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation, including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness, including psychological testing, except psychotherapy notes, to individuals representing American Fidelity who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. American Fidelity will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes and only to the extent allowed by law.

**Notice:** Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), or other conditions for which you may have been treated.

I understand that American Fidelity may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in American Fidelity not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity, P.O. Box 258897, Oklahoma City, OK 73125-8897 or by calling, toll-free, 1-833-541-0151. I understand that my right to revoke this authorization is limited to the extent that: American Fidelity has taken action in reliance on the authorization; or the law provides American Fidelity with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by federal privacy regulations. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon the termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Customer #

Printed Name of Patient

Patient's Date of Birth

Signature (Patient) or Personal Representative (if applicable)

Date Signed

Relationship of Personal Representative to Patient (if applicable)

*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the insured must be included.*

**Please retain a copy for your personal records, or you may request a copy from our company.**

## Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

**If you live in a jurisdiction not mentioned below, the following applies to you:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

**Alabama** - 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.

**Alaska** - 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.

**Arizona** - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia** - 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.

For your protection **California** law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

**Delaware, Idaho and Oklahoma** - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

**Indiana** - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky** - 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.

**Maine, Tennessee, Virginia and Washington** - 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/or a denial of insurance benefits.

**Maryland** - 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.

**Minnesota** - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire** - 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.

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

**New Mexico** - 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio** - Any person who, with 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.

**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.

**Puerto Rico** - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For your protection **Texas** law requires the following to appear on this form: 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.