Accelerated Living Benefit Claim

Please make sure that you have answered all questions completely and accurately. If there are unanswered questions, the review of your claim may be delayed. An Attending Physician's Statement must also be submitted to GBU Financial Life. **Please print clearly.**

Check all that apply:	☐ Chronic Illness	☐ Critical Illness	☐ Terminal Illness	
Insured's Legal Name *(First, Middle Initial, Last)*				
Street Address				
City		State	ZIP	
Phone	Email			
Social Security Number		Birthdate		
Marital Status *(Please check one.)*	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Have you received a written description of the Living Benefit Rider?			☐ Yes	☐ No
Are you self-employed at any activity?			☐ Yes	☐ No
Are you now working at your occupation or another occupation?			☐ Yes	☐ No
Are you covered under more than one insurance policy issued by GBU?			☐ Yes	☐ No
Have you applied for waiver of premium?			☐ Yes	☐ No

Have you or any other person insured under this policy been diagnosed by a member of the medical profession with one or more of the following health conditions *(Please check all that apply.)*

- ☐ Heart attack
- ☐ Stroke
- ☐ Cancer
- ☐ Major organ transplant
- ☐ End-stage renal failure
- ☐ Paralysis
- ☐ Severe cognitive impairment
- ☐ OTHER—Please describe below.
- ☐ Unable to perform at least two (2) Activities of Daily Living (ADL) without substantial assistance *(bathing, continence, dressing, eating, toileting and transferring)*

Describe your present medical condition.

Please provide the following information regarding any physicians who have treated you. Attach a separate sheet for additional physicians.

Physician's Name	Specialty	
Street Address		
City	State	ZIP
Phone	Date First Consulted	Date Last Consulted

Please indicate if you are currently confined to one of the following:	☐ Hospital ☐ Nursing Home.	☐ Yes	☐ No
If yes, date confinement began.	Is confinement permanent?	☐ Yes	☐ No

Please provide the name and address of the hospital or nursing home.

Name		
Street Address		
City	State	ZIP

Accelerated Living Benefit Claim *(continued)*

Insured's Legal Name *(First, Middle Initial, Last)*		
Are you currently receiving in-home care? If yes, is care ☐ Full-Time ☐ Part-Time	☐ Yes	☐ No
Please describe type of care		
By whom is in-home care provided?		
What amount of Accelerated Benefit are you claiming? ☐ ________________ OR ☐ $ ________________ ☐ 10% minimum* ☐ $5,000 minimum* ☐ 25% minimum* ☐ $250,000 minimum* ☐ 50% maximum* ☐ $500,000 minimum* ☐ 75% maximum* * *Subject to the terms in your policy, the minimums and maximums indicated here may vary. Please read the Accelerated Benefit provision in your policy.*		
Is part or all of your life insurance required to be paid to your children, spouse or former spouse as a part of a court-approved divorce decree, separate maintenance agreement or property settlement agreement?	☐ Yes	☐ No
Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)? **If yes, your spouse must complete the attached written consent for payment of an Accelerated Benefit.**	☐ Yes	☐ No
Have you made an assignment of all or part of your insurance? If yes, the assignee must complete the attached written consent for payment of an Accelerated Benefit. *(An assignment is a transfer of your rights under this policy; it does not refer to your beneficiary designation.)*	☐ Yes	☐ No
Have you filed for bankruptcy? If yes, the trustee in bankruptcy or other official of the bankruptcy court must complete the attached written consent for payment of an Accelerated Benefit. *(If you are covered under a policy issued in CT. IL or TX, you are not required to respond.)*	☐ Yes	☐ No
Are you required by a government agency to use the Accelerated Benefit to apply for, receive or continue a government benefit or entitlement? *(If you are covered under a policy issued in CT, you are not required to respond.)*	☐ Yes	☐ No
Have you previously applied for or received an Accelerated Benefit from GBU Financial Life?	☐ Yes	☐ No

I certify the above answers are true and complete and to the best of my knowledge arid belief from the basis of my claim for an Accelerated Benefit. I do understand that the receipt of an Accelerated Benefit may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, my Accelerated Benefit may be nontaxable, and these matters should be discussed with my tax and/or legal advisor before applying for an Accelerated Benefit. I further understand that this benefit provides for an accelerated payment of life insurance and is not intended nor designed to provide health, nursing home or long-term care benefits.

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Dated at ____________________________ , ___________, on ____________________________ , 20 _____.
City State Month and Day

______________________________ ______________________________
Signature of Insured Print Name of Insured

Accelerated Benefit Claim: Attending Physician's Statement

The patient is responsible for the completion of this form at their own expense. We require comprehensive medical information in order to evaluate the insured's claim for accelerated benefit. **Please print clearly.**

Part A. To Be Completed By Patient

Insured's Legal Name *(First, Middle Initial, Last)*		
Street Address		
City	State	ZIP
Phone	Email	
Social Security Number	Birthdate	
Gender *(Please check one.)* ☐ Male ☐ Female	Policy Number	

Part B. To Be Completed By Physician

The purpose of this form is to help us determine whether your patient is eligible for accelerated payment of life insurance proceeds. We need to evaluate the clinical condition of your patient. Please advise of any clinical findings including laboratory data and results of special tests such as X-rays, CAT scan, EKG, etc. Copies of any surgical reports, hospital discharge summaries, chart notes or narrative reports will be helpful.

Weight	Height	Blood pressure on last visit	Pulse
Diagnosis Primary		☐ Yes	☐ No
Secondary		☐ Yes	☐ No
ICDA Classification		☐ Yes	☐ No
Course of treatment	Medications		
Prognosis			
In your opinion, does the patient have a terminal condition?		☐ Yes	☐ No
What is the terminal condition?			
In your professional opinion, what is the patient's life expectancy? ☐ Less than 6 months ☐ 6 to 12 months ☐ Greater than 12 months ☐ Other			
Objective Findings—Objective documentation must be included to support life expectancy			
Symptoms			
When did symptoms first appear?			
Date you recommended patient should stop working	Why?		

Accelerated Benefit Claim: Attending Physician's Statement *(continued)*

Insured's Legal Name *(First, Middle Initial, Last)*

Dates and Nature of Treatment

A. Date of first visit	Date of last visit		
B. Frequency ☐ Weekly ☐ Monthly ☐ Other, **Specify**			
C. Will treatment substantially improve function and employability? If yes, specify		☐ Yes	☐ No
D. Have you made referrals?		☐ Yes	☐ No
If yes, specify	Specialty		
Name	Phone		

Progress

A. Has patient: ☐ Retrogressed ☐ Unchanged ☐ Improved ☐ Recovered		
B. Is patient: ☐ Hospital confined ☐ Bed confined ☐ House confined ☐ Ambulatory		
C. If patient has been hospitalized, please provide the name, address, and phone number of the hospital.		
Name		
Street Address, City, State and ZIP		
Admitted	Discharged	Phone

Limitation

Are the limitations permanent?	☐ Yes	☐ No

☐ Sitting ☐ Climbing ☐ Use of left hand/arm ☐ Bending ☐ Walking
☐ Stooping ☐ Lifting ☐ Use of right hand/arm ☐ Pushing/Pulling
☐ Other, clarify

Physical Impairment ****As defined in Federal Dictionary of Occupational Titles***

☐ Class 1—No limitation of functional capacity; capable of heavy work*; No restrictions
☐ Class 2—Medium manual activity*
☐ Class 3—Slight limitation of functional capacity; capable of light work*
☐ Class 4—Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity
☐ Class 5—Severe limitation of functional capacity; incapable of minimal (sedentary*) activity
☐ Remarks

Do you believe the patient is competent to manage insurance benefits?	☐ Yes	☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits?	☐ Yes	☐ No

List Other Treating or Referring Physicians

Name	Address and City, State and ZIP
1.	
2.	

Physician's Name	Specialty
Street Address, City, State and ZIP	
Phone	Taxpayer Identification Number

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Signature ____________________ Date ____________

FRAUD WARNING NOTICES

Some states require us to provide the following information to you:

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

California Residents. For your protection, California law requires the following to appear on this form: 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.

Colorado Residents. 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 the 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 Indiana Residents. WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony.

District of Columbia, Maine, Tennessee, Virginia and Washington Residents. WARNING: It is a crime to knowingly provide false, incomplete 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.

Florida Residents. Any person who knowingly and with intent to injure, defraud or deceive an insurance company, makes a statement of claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony of the third degree.

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

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

New Mexico Residents. 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 civil fines and criminal penalties.

New York Residents. 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Residents. 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.

Oklahoma Residents. 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.

Other Residents (AR, CT, GA, HI, IL, IA, KS, MA, MD, MI, MS, MO, MT, NE, NV, NC, ND, OR, RI, SC, SD, UT, VT, WV, WI and WY). 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.

Pennsylvania and Kentucky Residents. 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.

Accelerated Benefit Claim: Fraud Notices *(continued)*

Fraud Notice: The statements on the previous page are true and complete to the best of my knowledge and belief. *Please print or type clearly.*

Physician's Name			Degree	
Medical Specialty				
Street Address, City, State and ZIP				
Phone	Fax Number			
Signature of Physician			Date	
Taxpayer Identification Number				
Are you, the physician, related to the patient? If yes, what is the relationship?		☐ Yes	☐ No	

Accelerated Benefit Claim: Authorization to Release Medical Information

I AUTHORIZE any physician; medical practitioner; hospital; clinic; other medical or medically related facility; to give the Company or its reinsurer(s) all information it holds that pertains to medical consultations; treatments; surgeries; and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes a pharmacy benefits manager; insurance support organization; pharmacy/government agency; insurance or reinsuring company; MIB, Inc. (“MIB”); consumer reporting agency; or any other organization; institution; or person. This authorization also includes information about drugs and alcoholism or any other non-health (non-medical) history information.

I authorize the Company and its reinsurers to release any information including my physical health information obtained to reinsuring companies; MIB; or other persons or organizations performing business or legal service in connection with my application or claim. I further authorize the Company and its reinsurers to release any information that may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be valid as the original and that it will be valid for 30 months from the date shown below. This time limit is permitted by applicable law in the state where the policy is delivered or issued for delivery.

Fraud Warning. 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 the state law.

Dated at ______________________________ , ___________, on ________________________________ , 20 _____.
City State Month and Day

_______________________________________ _______________________________________
Signature of Proposed Insured Signature of Policy Owner

_______________________________________ _______________________________________
Printed Name of Proposed Insured Printed Name of Policy Owner

Investigative Consumer Reports

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates.

Important Notice

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been treated.

NOTIFICATION REGARDING MIB, INC. (“MIB”): Information regarding your insurability will be treated as confidential. GBU Financial Life or its reinsurers may, however, make a brief report thereon to the MIB. The MIB is a not-for-profit membership organization of insurance companies operating an information exchange on behalf of its members. The MIB may also release information in your file to another MIB-member company to whom application may be made for life or health insurance coverage; or, a benefit claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at[866-692-6901. If you question the accuracy of information in MIB’s file; you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. MIB’s information office address: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

GBU Financial Life or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance; or, to whom a claim for benefits may be submitted. Information for consumers about the MIB may be obtained at its website **www.mib.com**.

THIS NOTIFICATION MUST BE GIVEN TO THE PROPOSED INSURED BEFORE THE APPLICATION IS COMPLETED.

Accelerated Benefit Payment Consent

STATE OF ____________________

County of

SS.

The undersigned, on oath being first duly worn, depose and say:

My relationship to ____ is:
Name of Insured

☐ Spouse living in a community property state
☐ Assignee under an assignment
☐ Trustee in bankruptcy or other official of the Bankruptcy Court

I understand that the Insured is making application to GBU Financial Life (GBU Life or GBU) for the payment of an Accelerated Benefit in the amount of $ _______ under an individual life insurance policy. I consent to the payment by GBU to the Insured of the Accelerated Benefit should GBU determine the Insured to be eligible.

____
Signature

Subscribed and sworn to before me this _______________ day of _______________

Notary Public
for the State of _____________

My commission expires_______