

Annuity Accelerated Living Benefit Claim



4254 Saw Mill Run Blvd., Pittsburgh, PA 15227

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 (pages 2 and 3) must also be submitted to GBU Financial Life (GBU Life). **Please print clearly.**

Contract Number

Check all that apply: Terminal Condition Home Health Care Activities of Daily Living
 Nursing Home Confinement Critical Illness Severe Cognitive Impairment

Annuitant Printed Legal Name (First, Middle Initial, Last)

Street Address

City

State

Zip Code

Phone

Email

Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)?

Yes No If yes, your spouse must complete the written consent for payment of an Accelerated Benefit.

Have you previously applied for or received an Accelerated Benefit from GBU Life?

Yes No

Acknowledgement

I certify the above answers are true and complete to the best of my knowledge and 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 non-taxable, 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 an annuity and is not intended nor designed to provide health, nursing home or long-term care benefits.

Owner Signature

Date

Owner Printed Legal Name

City

State

Joint Owner Signature (if applicable)

Date

Joint Owner Printed Legal Name (if applicable)

City

State

Phone: 412-884-5100 | 800-765-4428 | service@gbu.org | gbu.org



Attending Physician's Statement

The patient is responsible for the completion of this form at their own expense. We require comprehensive medical information to evaluate the insured's claim for accelerated benefit. Please print clearly and complete the sections of the form that apply.

Contract Number _____

Part A. To Be Completed By Patient

Male Female

Insured Legal Name (First, Middle Initial, Last) _____

Street Address _____

City _____

State _____

Zip Code _____

Phone _____

Email _____

Social Security Number _____

Date of Birth _____

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 annuity proceeds. We need to evaluate the clinical condition of your patient. Please complete this section for the patient listed above.

Please print clearly.

Has the patient been diagnosed with one or more of the following health conditions? Yes No

If yes, please check all that apply and provide the date of occurrence.

Heart attack _____

End-stage renal failure _____

Stroke _____

Severe Cognitive Impairment _____

Cancer _____ (type of cancer) _____

Continues on next page.



Annuity Accelerated Living Benefit Claim, *continued*



Is the patient unable to perform at least two Activities of Daily Living (ADL) without substantial assistance? Yes No

If yes, please check all that apply and provide the date of occurrence.

Bathing _____

Eating _____

Continency _____

Toileting _____

Dressing _____

Transferring _____

Is the patient receiving treatment by one of the following?

If yes, please check all that apply and provide the date treatment started.

Nursing Home _____

Home Health Care _____

How many consecutive days has the patient received treatment? _____

Please provide the name and address of the nursing home or home health care:

Facility Name

Street Address

City

State

Zip Code

In your opinion, does the patient have a terminal condition? Yes No

What is the terminal condition? _____

Date the condition became terminal: _____

In your professional opinion, what is the patient's life expectancy?

Less than 6 months 6 to 12 months Greater than 12 months Other _____

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.

Physician Signature

Date

Continues on next page.

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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.

Owner Signature		Date
Owner Printed Legal Name	City	State
Joint Owner Signature (if applicable)		Date
Joint Owner Printed Legal Name (if applicable)	City	State

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 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 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.



Written Consent For Payment of an Accelerated Benefit

This form is only required if you are married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin).

By signing this form, I acknowledge that I have been fully informed about the financial and legal implications of my consent, including that:

Reduced Death Benefit: I understand that payment of accelerated benefits will reduce the amount of the death benefit that would otherwise be payable upon my spouse's death.

Reduction of Other Policy Benefits: I understand that other benefits provided under the policy, such as living benefits or future policy value, may also be reduced by the payment of accelerated benefits.

Waiver of Rights: I understand that by signing this consent form, I waive any rights or claims I may have under the policy to the full original death benefit or other benefits, and I release the insurance company from any responsibility or liability regarding the policy's future value.

Voluntary Consent: I confirm that my consent is given freely and voluntarily, without any coercion or undue influence. I have had the opportunity to consult with legal or financial advisors if I chose to do so.

Annuitant Name

Annuitant Signature	Date

Spouse Name

Spouse Signature	Date