

Equitable Reserve Association

A Not-For-Profit Fraternal Life Insurance Association, est. 1897

Instructions for Living Need Accelerated Death Benefit Claim Form

Living Need Accelerated Benefit Rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Primary Insured, when the Primary Insured is diagnosed as having a "Terminal Illness". This is treated as an advance against the death benefit, reducing the policy's death benefit accordingly. Descriptions of major provisions and an illustration of the effect on policy values follow. Please complete Financial and Medical Records Authorization Form 426 and the Living Need Accelerated Death Benefit Claim Form. Your attending physician should complete his/her statement without expense to the Association.

Mail completed form to:
Equitable Reserve Association
Attn: Claims Department
P.O. Box 448
Neenah, WI 54957-0448

Keep a copy of the completed form for your records.

Call the Claims Department at 1-800-722-1574 if you have any questions or concerns.



116 S. Commercial Street • Neenah, Wisconsin 54956

FINANCIAL AND MEDICAL RECORDS AUTHORIZATION

(This authorization complies with the HIPAA Privacy Rule)

Purpose: Consideration of a Life Insurance or Disability Income Insurance Application

Give completed and signed copy to the proposed insured.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB) or health care provider that has provided payment, treatment or services to me (“My Providers”) to disclose the entire medical record and any other protected health information concerning me to Equitable Reserve Association and their agents, employees and representatives. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by #164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Equitable Reserve Association, 116 S. Commercial Street, Neenah, WI 54956, Attention: New Business Department. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that Equitable Reserve Association has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Equitable Reserve Association will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Equitable Reserve Association may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

SSN of Proposed Insured _____

Date of Birth of Proposed Insured _____

Address _____

Equitable Reserve Association

LIVING NEED ACCELERATED DEATH BENEFIT CLAIM FORM

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.

HOW TO FILE A CLAIM

1. Claimant complete the accelerated death benefit payment request with appropriate signatures.
2. Claimant complete Part A on reverse side.
3. Physician complete Part B on reverse side.
4. Return form to Member Benefits Department.
5. For answers to any questions on how to complete this form, please call 1-800-722-1574.
6. Complete Form 115 Authorization and return with this form.

The accelerated benefit payment is requested under the life insurance policies listed.

Policy No(s). _____

Amount of Benefit
Advance Requested \$ _____ + \$ _____ + \$ _____

Total= \$ _____

Statement of Member

Name (Please Print) _____ Phone No. _____

Most Recent Hospitalization – From _____ Through _____ Name of Hospital _____

Address of Hospital _____ City _____ State _____ Zip _____

Name and Address of Doctors Consulted _____

Date First Treated _____ Date Last Seen _____

What is your understand of your condition (health)? Please describe. _____

I certify that all the above statements are complete and accurate to the best of my knowledge.

Signature of Member _____ Date _____ Signature of Witness _____ Date _____

Address _____

If the certificate is owned by other than the insured or has an irrevocable beneficiary please sign below.

Signature if Owner (if other than insured) _____ Date _____

Signature of Irrevocable Beneficiary _____ Date _____

Part A**To Be Completed By Patient (Insured)**

Name of Patient _____ Date of Birth: Mo. _____ Day _____ Year _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

Signed (Patient, or Parent if Minor)_____
Date

Part B**Attending Physician's Statement**

1. To Physician

The patient is requesting an accelerated benefit payment on life insurance.

Your statement is needed to determine patient's eligibility.

2. History

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____

(b) Date patient informed of diagnosis. Mo. _____ Day _____ Year _____

(c) Has patient ever had same or similar condition? Yes NoIf yes, state when and describe. _____
_____**3. Diagnosis and Prognosis**(a) Do you believe the patient's condition is terminal? Yes No

(b) Best estimate of life expectancy _____

(c) Diagnosis (including any complications)

(d) Subjective symptoms

(e) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

(f) In your opinion has this condition affected the mental capacity of the patient? Yes No(g) In your opinion is the patient mentally competent to endorse checks? Yes No(h) Other comments

4. Dates of Treatment

(a) Date of first visit Mo. _____ Day _____ Year _____

(b) Date of last visit Mo. _____ Day _____ Year _____

(c) Frequency Weekly Monthly Other (Specify) _____

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

6. Has patient been hospital confined? Yes No If yes, confined from _____ through _____Name and Address of Hospital _____

Print
Physician's Name _____ Degree _____ Specialty _____ Telephone _____Street Address _____ City _____ State _____ Zip Code _____

I certify that the above information is complete and accurate to the best of my knowledge.

Physician's Signature _____ Date _____