

# Equitable Reserve Association

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

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## **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 \_\_\_\_\_



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

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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

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**Part B****Attending Physician's Statement**

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**1. To Physician**

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

Your statement is needed to determine patient's eligibility.

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**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

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**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) \_\_\_\_\_

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

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**6. Has patient been hospital confined?**  Yes  No If yes, confined from \_\_\_\_\_ through \_\_\_\_\_Name and Address of Hospital \_\_\_\_\_

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Print  
Physician's Name \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone \_\_\_\_\_Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_