

**NATIONAL BENEFIT LIFE INSURANCE COMPANY
HOME OFFICE: LONG ISLAND CITY, NEW YORK**

NOTICE

This claim form is being sent to you on _____20____. You must complete and sign it by _____, 20__ (30 days from the first date). Within five days of our receipt of this form from you, we will send you more information about your policy and this Accelerated Benefit. New York law prohibits us from paying this claim for 14 days after we send you this additional information.

INSTRUCTIONS

1. Please use this form when filing for Terminal Illness Accelerated Benefits. This form must be completed by the OWNER of the policy.
2. Please complete in full all sections of page 2 and 3. The Policyowner must sign page 3 of this form and the signature must be notarized.
3. If the Policyowner is unable to sign page 3, the person empowered to act for the Policyowner must sign and the signature must be notarized. Attach the supporting document, i.e. Power-of-Attorney, or Guardianship/Conservatorship Appointment.)
4. Page 4 must be completed and signed by the Policyowner. The signature on this page must also be notarized. See special instructions at top of page 4.
5. Page 5 of this form must be signed by any irrevocable beneficiary and assignee, and the signatures must be notarized. See special instructions at top of page 4.
6. The Owner, Insured or any Irrevocable Beneficiary must also sign page 5 and the signatures must be notarized. If there is more than one beneficiary, a separate beneficiary release will be included for each beneficiary to sign. Spouse/Former Spouse need to only sign in Community Property States.
7. If the Owner, Insured or any Irrevocable Beneficiary is a minor, or is incapacitated, the Release and Agreement must be executed by the Guardian/Conservator and Letters of Guardianship/Conservatorship must be attached.
8. The Authorization on page 6 must be signed by the patient or person empowered to act for the patient. This signature must be witnessed.

**NATIONAL BENEFIT LIFE INSURANCE COMPANY
HOME OFFICE: LONG ISLAND CITY, NEW YORK**

**TERMINAL ILLNESS
ACCELERATED BENEFITS CLAIM FORM**

CLAIMANT'S STATEMENT

General Notice: In order for the Owner of the Policy to receive Terminal Illness Accelerated Benefits, the Company must receive acceptable proof that the Insured has a Terminal Illness as defined in the Policy. All relevant supporting information must be received by the Company before a final determination of the Benefits can be made.

Insured's Name: _____	Policy No.(s): _____
-----------------------	----------------------

Street Address: _____

City, State and Zip Code: _____

Telephone Number: () _____ Birthdate: ____/____/____ SSN: ____/____/____

Please describe the medical condition resulting in the Insured's Terminal Illness: _____

The names, addresses, and phone numbers (including area codes) of the Insured's doctors:

Dr. _____	Dr. _____	Dr. _____
-----------	-----------	-----------

() _____	() _____	() _____
-----------	-----------	-----------

Date first treated: _____	Date first treated: _____	Date first treated: _____
Date last treated: _____	Date last treated: _____	Date last treated: _____

The following person is authorized to answer questions about this application if the Insured and/or the Owner is not available or unable to do so.

Name: _____
Address: _____

City _____ State _____ ZipCode _____
Phone: (____) _____
Area Code
Relationship to the Insured: _____

Is there an Irrevocable Beneficiary on this Policy? Yes No

If yes, print Irrevocable Beneficiary name: _____

Is there an assignment of this Policy? Yes No

If yes, print assignee name: _____

The owner is responsible for the continued payment of premiums for this Policy unless a Waiver of Premium rider was purchased for this Policy and this Terminal Illness Accelerated Benefit Claim is approved.

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for accelerated death benefits, policyowners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, policyowners should seek assistance from a qualified tax advisor.

The payment of this Accelerated Benefit will reduce the death benefit payable to your Beneficiary under the Policy by the amount of the Accelerated Benefit plus administrative fee and interest.

No health care facility, as defined in Section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

National Benefit Life Insurance Company is prohibited from paying accelerated death benefits to the policyowner for a period of 14 days from the date on which we sent you additional information about this claim. We will send you this additional information within five days of our receipt of this claim form.

The undersigned hereby applies for and agrees to the Terminal Illness Accelerated Benefits as described in the Policy. I agree to release all interest in the Policy to National Benefit Life Insurance Company and hold the Company harmless from any liability including reasonable attorney's fees that it may incur by reason of payment of the Accelerated Benefit.

This claim form is submitted voluntarily and without coercion by any third party.

Owner's Name: _____

Notary Public:

State of: _____ County of _____

Owner's Social Security Number: ____/____/____

Before me the undersigned, a Notary Public, personally appeared _____

And acknowledged the execution of this instrument this _____ day of _____ 20____

Owners Signature: _____

(Seal)

(Signature)

Print or Typed Name

ASSIGNMENT OF POLICY AS COLLATERAL SECURITY

Special Instructions: When applying for the Accelerated Benefit, we will need all signatures in the situations listed below as applicable.

1. Owner of the Policy must sign this form.
2. Community property states require the signature of the spouse of the current Policyowner. Please see the special instructions in the enclosed cover letter.
3. If the Policy is owned by a corporation or association, this form must be signed by a duly appointed officer in that capacity.
4. If the owner is legally incompetent, guardian or conservator must sign.
5. All signatures must be notarized.

Policy Number (s):	Insured:	Owner (if other than insured):
--------------------	----------	--------------------------------

For value received, the receipt of which is hereby acknowledged, and as security for the indebtedness hereinafter mentioned, the undersigned does hereby sell, assign, transfer, set over and convey unto NATIONAL BENEFIT LIFE INSURANCE COMPANY, all right, title and interest in and to the Policy described above. This assignment is intended to secure indebtedness and results in a lien to the assignee as may exist at the time of final settlement under this Policy and this assignment is expressly limited to such of the proceeds under the Policy as may be necessary to liquidate said indebtedness.

- | | | |
|----|-------------------------|------|
| 1. | Owner | Date |
| 2. | Owner | Date |
| 3. | Officer & Title | Date |
| 4. | Guardian or Conservator | Date |

Notary Public:

State of: _____ County of _____

Before me the undersigned, a Notary Public, personally appeared

_____ And acknowledged the execution of this instrument this
_____ day of _____ 20____

(Seal)

(Signature)

Print or Typed Name

My commission expires: _____

Release and Agreement

Policy Number (s):	Insured:	Owner (if other than insured):
--------------------	----------	--------------------------------

For value received, the receipt of which is hereby acknowledged, the undersigned whether in the capacity as Owner or Assignee, does hereby release all rights, title and interest in the above referenced Policy(s) and release National Benefit Life Insurance Company from any and all liens arising out of the request by the Owner that amounts be paid and/or amounts actually paid plus costs incurred under the Accelerated Benefits provision of the Policy(s). I have carefully read and understand this document and the Accelerated Benefits provision of the Policy.

Dated and signed at: _____	_____
City and State	Date
_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Owner

Notary Public:

State of: _____ County of _____

Before me the undersigned, a Notary Public, personally appeared

_____ And acknowledged the execution of this instrument this _____ day of _____ 20_____

(Seal)

(Signature)

Print or Typed Name

My commission expires:

**NATIONAL BENEFIT LIFE INSURANCE COMPANY
HOME OFFICE: LONG ISLAND CITY, NEW YORK**

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Company.

Terminal Illness

Patient's Name: _____ Age: _____

Date of first visit Mo. Day Year

Date of last visit Mo. Day Year

Date total disability began Mo. Day Year

Diagnosis:

Is the patient mentally capable of handling his/her own affairs?

Yes [] No []

Present Condition:

Objective finding (include any results of relevant tests, studies or findings on examination):

If hospitalized:

Name of Hospital: _____ Address: _____ Date Confined _____

To qualify for this benefit, the patient must have a life expectancy of six (6) months or less. In your estimation, does the patient meet this requirement:

Yes [] No []

If you feel it would be helpful to our evaluation of this claim, please include a copy of the most recent hospital and office notes.

Physician's Signature Date Telephone Number

Address City State Zip code