FOR ASSISTANCE
Call Toll Free
1-800-221-2554

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: _____

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

Owners Signature: _____

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:

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

AUTHORIZATION

IMPORTANT: To avoid delay, please sign authorization below:

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide National Benefit Life Insurance Company, its officers, employees, agents, or legal representatives, and any insurance support organization and consumer reporting agency acting on the Company's behalf, with any and all medical records and personal information including privileged information.

I UNDERSTAND that this Authorization will be used to obtain information on the diagnosis, treatment and prognosis with respect to any physical or mental condition as well as the use of drugs or use of alcohol.

I UNDERSTAND that the information obtained by use of this Authorization will be used by the Company or its Agents, to determine eligibility for benefits under an existing policy.

I KNOW that I or my legal representative may receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I UNDERSTAND that the duration of the Authorization is for the duration of all claims under the Policy.

Signed this_____day of _____, 20_____

_____
Signature of Patient

_____
Signature of Witness

_____
Witness Address City State Zip code

If the patient is unable to sign, please have the person who is empowered to act for the patient or next of kin sign below:

_____
Signature

_____
Address City State Zip code

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