AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2500 • Waco, TX 76797

Phone (254) 761-6400 • Fax (254) 741-5705 • www.ailife.com

For your protection, laws in certain jurisdictions require the following to appear on this form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ACCELERATED BENEFIT REQUEST FORM CLAIMANT STATEMENT

Part A

Name _____ Policy No. _____

1. What is the nature of your medical condition? _____

_____

2. Have you had or received treatment for this condition prior to this occurence?
   ☐ Yes ☐ No If Yes, when? _____

3. Onset date of this medical condition. Month _____ Day _____ 20 _____

4. Date first treated for this medical condition by a physician.

_____

5. When were you first informed that you had a terminal illness?

_____ By Whom? _____

6. Provide name and address of above physician. _____

_____

7. Provide the name(s) of any physician you have seen in the past five (5) years and indicate the medical condition treated.

_____ _____

_____ _____

_____ _____

_____ _____

8. Have you made a claim to any other Insurance company for the same or similar benefits? ☐ Yes ☐ No
   If Yes, list name and address of the company. _____

_____

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Claimant's Signature:		Date of Birth:
Date:	Social Security Number:	Phone No:

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ACCELERATED BENEFIT REQUEST FORM PHYSICIAN'S STATEMENT

Part B - TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Patient's Name _____ Policy # _____

1. Diagnosis _____

_____

Complications, if any. _____

_____

2. When, in your opinion, did this terminal illness first begin? _____

_____

3. When did patient first consult you for this terminal illness? _____

4. When was patient first notified that he/she had a terminal illness? _____

By whom? _____

5. What is the likelihood that the patient will recover from this illness? _____

_____

6. What form of treatment has been recommended for this illness? _____

_____

_____

7. Has the patient agreed to undergo the above treatment? ☐ Yes ☐ No

8. Based on your medical evaluation, does the patient named above have a "terminal illness"? ☐ Yes ☐ No

9. Is it your professional medical opinion that the above named patient has a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the patient within the next twelve (12) months?

☐ Yes ☐ No

_____

Physician's Name (Please print)

_____ _____

Physician's Address Phone

_____ _____

Signature of Physician Date