



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200

Accelerated Death Benefits Statement of Claim

(To Avoid Delay Please Answer All Questions)

Employer's Statement

1. Employee's Name		2. Employee's Social Security No.	
3. Group Policy Number	4. Amount of Life Insurance	5. Employee's Date of Hire	
6. Employee's Eff. Date of Insurance	7. Employee's Last Date Worked	8. Reason Employee Stopped Work	
9. Employee's Occupation at Time Stopped Work		10. Do You Expect Employee to Return to Work <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Name		Date	
Signature		Title	
Name (Please print or Type)		Telephone ()	
Street Address		City, State, ZIP	

Employee's Statement

1. Full Name (Last, First, Middle)			2. Benefit Amount Requested <input type="checkbox"/> Maximum Amount Available <input type="checkbox"/> \$ _____	
3. Date of Birth	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Height	6. Weight	7. Date Symptoms Appeared
8. Describe nature of illness or injury				
9. Date of First Treatment		Treated by: Doctor _____ Name Address City, State, ZIP		
10. Have You Made An Absolute Assignment Of This Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, to whom: Name _____ Address _____				
11. Is This Insurance To Be Paid To Your Children/Former Spouse Under A Court Ordered Agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No				
12. Have You Designated Anyone as an Irrevocable Beneficiary of these Proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please have Beneficiary complete the Irrevocable Beneficiary Consent				

IRREVOCABLE BENEFICIARY CONSENT

Name		Social Security No.	Date of Birth
Address (include Street, City, State and ZIP)			Telephone ()

I, the undersigned irrevocable beneficiary of the above described life insurance benefits, do hereby consent to the payment of the Accelerated Death Benefits and understand this will result in a lesser amount of life insurance benefits which will be payable to me at the time of the insured's death. I further agree to release and hold harmless US Able Life from any and all causes of action which I may now have, or which may arise in the future, resulting or related to the payment of the Accelerated Death Benefits.

Date	Signature of Irrevocable Beneficiary		
Date	Witness (CANNOT Be the Employee)	Signature	
	Address	Telephone	

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.

Date	Signature of Claimant/Employee
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Attending Physician's Statement

Name of Patient _____	Date of Birth _____
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1. History

a. When did symptoms first appear? Date: _____

b. Has patient ever had same or similar condition? Yes No

If so, when? Date _____

2. Diagnosis _____ _____ _____	ICD-9 (Must have to Process) _____ _____ _____
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3. Objective Findings. (Please specify and include current radiology, EKG and laboratory data.)

4. Dates of Treatment

a. Date of first visit _____

b. Date of last visit _____

c. Frequency of visits _____

5. Nature of Treatment (Include surgery and medications.)

6. Progress

a. Has patient (check one) Recovered Improved Unchanged Worsened

b. Is patient (check one) Ambulatory House Confined Bed Confined

7. Prognosis (Please be specific)

8. Remarks

9. Physician's Signature	Provider Tax ID #	Date
Physician's Name (Please Print/Type)	Degree	Telephone ()
Address (Include Street, City, State and ZIP)	Fax ()	

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