

Initial Claim Form for ACCELERATED BENEFITS

This form should be prepared by the employee, his attending physician and employer. Immediately after the diagnosis of a terminal illness for which a claim is being submitted. Forward completed claim forms to:

Lincoln Mutual Life and Casualty Insurance Company
4510 13th Avenue South • Post Office Box 1918
Fargo, North Dakota 58107-1918

Attach a separate statement if space provided on the form is inadequate for complete answers. By furnishing this claim form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

Insured's Statement

Name of Employer _____ Group # _____
Name of Insured _____ Date of Birth _____
Social Security No. _____ Sex _____
Address of Insured _____
When did terminal illness begin _____ 20_____
Describe nature of terminal illness _____
_____ Name of attending physician
If confined in hospital, give name and address of hospital _____

Admitted (give dates and times) _____ Discharged _____

Do you understand that any payment of the accelerated benefit will reduce the death benefit payable under this policy?

Yes No

Are any benefits under this group policy assigned, or payable as part of a divorce settlement?

Yes No

The above Statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish to the Insurance Company providing this form, or their representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions treatments or benefits, and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Signature of Insured

Date

Employer's Statement

Name of Insured _____ Date Hired _____
Social Security # _____ Job Title _____
Policy Effective Date _____ Amount of basic coverage _____

Last date and times worked? _____

Date & time returned to work _____

If not back to work, do you expect Insured to return to work? _____

Do you recommend payment of this claim? Yes No

REMARKS: _____

Employer _____ Group Number _____
Mailing Address _____ Telephone (____) _____

By _____ Title _____ Dated _____ 20_____
Authorized Company Representative

The receipt of a Living Benefit MAY be taxable income to you, seek advice from your PERSONAL TAX ADVISOR.

Attending Physician's Statement Accelerated Benefit Claim Form

Patient's Name _____

Diagnosis

Nature of sickness or injury (describe complications, if any) _____

Prognosis _____

When did symptoms first appear or accident happen? _____

When did patient first consult you for this condition? _____

Is condition due to any intentionally self-inflicted injury or suicide attempt? _____

Services

List Non-Surgical Treatments and Dates _____

List Surgical Procedures and Dates _____

Physician's Statement

Is patient still under your care for this condition? Yes No

Do you consider this condition terminal? Yes No

In your medical judgment, how long is the life expectancy of this patient? _____

Name of Physician (Type or Print) _____

Signature of Physician _____ Date _____

Address _____

City _____ State _____ Zip _____ Telephone _____