KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988, Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: Service@kemperbenefits.com Website: kemperbenefits.com

ACCELERATED DEATH BENEFIT RIDER CLAIM FORM
CHRONIC ILLNESS

Instructions to File a Claim:

1. Please complete Insured's Statement and mail or fax the completed form to the address or fax number indicated above. If more space is needed, please attach a separate piece of paper with the additional information.
2. Please have the treating physician complete the Attending Physician Statement. Your physician may mail or fax the completed form to the address or fax number indicated above.
3. Please have your physician provide the applicable documents in order to avoid delay in processing.
4. An Accelerated Death Benefit may be taxable. You should consult your personal tax adviser about the impact of any benefit received under this rider. Any benefit received under this rider may impact the recipient's eligibility for Medicaid or other government benefits. Any benefit paid under this rider will reduce the policy's death benefit and cash value. See the effect on the policy provision of this rider for more information.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)
Date of Birth	Diagnosis? (Please use ICD-9 codes)
When did symptoms first appear?	Has the patient ever had the same or similar condition?

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

_____

_____

Please provide the names, address, and phone numbers of any other treating physicians:

_____

_____

Please provide the name, address, and phone number of the nursing home facility or assisted living facility:

_____

_____

Please indicate the percentage (up to 25%) of the Death Benefit you wish to advance _____%

Is there an Irrevocable Beneficiary on the Policy? Yes or No

If yes, please print Irrevocable Beneficiary's name and address: _____

Is there an assignment of this Policy? Yes or No

If yes, print assignee's name:_____

Please indicate if there is someone authorized to answer questions about this application if the Policyholder is unable to do so or not available:

Name:_____ Phone:_____

Address:_____Relationship:_____

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE_____ INSURED'S SIGNATURE:_____

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Chronic Illness Attending Physician's Statement

Patient's Full Name:	Policy or Certificate Number:	Date of Birth:
Date of Initial Visit:	Date of Last Visit:	
Diagnosis:	Date of Diagnosis:	Total Disability Began:

Is the patient mentally capable of handling his/her own affairs? YES NO

Is the patient unable to perform (without substantial assistance from another individual) any Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity? YES NO

Please indicate which of the Activities of Daily Living the patient is unable to perform:

_____

_____

_____

Does the patient require substantial supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment? YES NO

Please provide clinical documentation including objective findings, clinical evidence, and standardized tests.

Please provide the names, address, and phone numbers of the nursing home facility or assisted living facility:_____

_____

_____

Please attach any additional information of the most recent hospital, office notes, and/or medical documentation if you feel it would be helpful in our evaluation of this claim.

Date:	Physician's Name (Print):	Signature:	Degree:	Phone Number:

Street Address:	City:	State:	Zip:	Tax Identification Number: