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
CRITICAL 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)

Nature of illness:	When have you had this same or similar condition?

When did symptoms first appear?	Date first diagnosed?	Date first treated?

Name and address of physician (list all physicians consulted):

Have you been confined to a hospital for this condition? Yes No Admission date: Discharge date:	Please provide name and address of hospital:

Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? Yes No If yes, when?

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

Is there an Irrevocable Beneficiary on the Policy? Yes No

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

Is there an assignment of this Policy? Yes 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_____ SIGNED:_____

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

Critical Illness Attending Physician's Statement

1. Patient's Full name	2. Policy or Certificate Number
3. Date of Birth	4. Diagnosis? (Please use ICD-9 codes)
5. When did symptoms first appear?	6. When did the patient first consult you for this condition?

CANCER

Please circle if cancer was **pathologically diagnosed** or **clinically diagnosed.** Date of diagnosis (date of biopsy): _____ (Please attach copy of pathology report or if clinically diagnosed, please provide reasons that pathological diagnosis was not obtained and attach medical documentation that supports diagnosis of Cancer)	Has the patient ever had the same or similar condition? YES NO If so, when?

HEART ATTACK/MYOCARDIAL INFARCTION

Has the patient shown an elevation of cardiac enzymes? YES NO

Were there associated new electrocardiographic (EKG) changes consistent with injury? YES NO

Were there confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms? YES NO

Date of diagnosis for myocardial infarction? _____

(Please attach copies of EKG, lab results, and other diagnostic test results.)

STROKE

Has a cerebrovascular event occurred resulting in permanent neurological impairment including infarction, hemorrhage or embolization of brain tissue from an extra-cranial source? YES NO

Have there been documented neurological deficits for at least 30 days? YES NO

Have there been confirmatory neuron-imaging studies? YES NO

(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)

END-STAGE RENAL FAILURE

Has there been chronic, irreversible failure of the function of both kidneys? YES NO

Has the patient undergone hemodialysis or peritoneal dialysis on a weekly basis? YES NO

(Please attach copies of medical records documenting end-stage renal failure and frequency of dialysis).

MAJOR ORGAN TRANSPLANT SURGERY

Has the patient been the recipient of a human-to-human transplant of a heart, lung, heart-lung, liver, kidney, or pancreas? YES NO (Please attach copy of operative report).	Date of surgery:

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

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