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
# TERMINAL 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 Terminal Illness:

_____

_____

_____

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

_____

_____

_____

Please indicate the percentage (up to 50%) 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 SIGATURE:_____

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## Terminal 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 Total Disability Began: | |

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

Present Condition:

_____

_____

Objective Findings (please include copies of test results, studies and/or findings):

_____

_____

If hospitalized, please indicate name of hospital, address, and dates of confinement:

_____

_____

_
_____

**To qualify for this benefit, the patient must have a life expectancy of six (6) months or less. In your estimation, does the patient meet this requirement?:** YES NO

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: |
|---|---|---|---|---|