KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
A **Kemper Health** Company

P.O. Box 147, Fort Mill, SC 29716-0147
Telephone: 877.851.0890 Fax: 877.721.2343
Email: newgroup@kemperbenefits.com Website: kemperbenefits.com

DEATH BENEFIT CLAIM FORM

Beneficiary Statement Instructions:

1. Please complete and sign Claimant's Statement. The beneficiary or claimant is to complete the Claimant's Statement. If more space is needed, please attach a separate piece of paper with the additional information.
2. If the policy is payable to the Estate or to the Executors or Administrators of the Insured, the Claimant's Statement should be executed by the Executor or Administrator. A certificate of appointment must be furnished.
3. If there are two or more beneficiaries, any one of them may complete the Claimant's Statement on behalf of all, in which case the full name, address, date of birth and social security number of each beneficiary is to be shown.
4. If the certificate is payable to a minor or a mentally incompetent person, a guardian should complete the statement, a certified copy of appointment must be provided.
5. Please provide a CERTIFIED COPY OF THE DEATH CERTIFICATE, indicating the cause of death. A certified copy of the death certificate of any deceased beneficiary must also be furnished.
6. If cause of death is due to an injury or accident, please provide a copy of the police report and and/or newspaper articles concerning the death.
7. Employer's Statement portion must be signed and completed by an authorized representative of the employer of the policyholder.
8. Please include a photocopy of the Insured's Enrollment Form.

Insured/Claimant Statement

Deceased's Full Name	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Deceased's Address (Street, City, State, Zip)		Place of death		
Beneficiary's Full Name	Beneficiary's Social Security No.		Beneficiary's Date of Birth	
Beneficiary's Daytime Phone Number	Beneficiary's Address			

Names of all physicians or practitioners who attended the deceased within five years preceding death. *(attach additional sheet if needed)*

Names	Addresses	Dates of Attendance	Diseases/Conditions
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Please indicate any other policies with this company:

____

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 AND 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.

Claimant/Beneficiary's Signature:______________________________________ Date________________

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Employer's Statement

Deceased's Full Name:	Employee's Name:	Group Policy #:	Employee's Social Security No.:
Name of Company:			Employee was: Salaried Hourly
Date Insured/Employee	Date Insured/Dependent	Date of Hire	Did injury occur on duty? Yes No
Cause of Death	Date and Time of Death	Amount of Insurance	Amount of Claim
Was premium paid and insurance in force at the time of loss? Yes No			

Printed Name of Authorized Representative: ___________________________________ Signature of Authorized Representative: ________________________________ Title: ________________________

Date: ______________________ Phone Number: __________________________ Fax Number: ___________________________

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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 physician's:
____
____
____

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:_____________________________

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Insured's Signature:____Date:________________________

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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:

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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 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 physician's:
____
____

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:_____________________________

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Insured's Signature:____ Date:_______________________

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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, 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: