Accelerated Benefit Claim Statement—Insured/Spouse

ASSURANT
Employee
Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of California, the following statement applies to you:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in Colorado, the following statement applies to you:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

If you live in New Hampshire, the following statement applies to you:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms “we,” “us,” “our,” and the like, refer to each as applicable.

If you live in New York the following statement applies to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in a state other than mentioned above, the following statement applies to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Accelerated Benefit Claim Statement—Insured/Spouse

ASSURANT Employee Benefits®

IMPORTANT NOTICE: RECEIPT OF AN ACCELERATED BENEFIT WILL REDUCE YOUR DEATH BENEFIT. ALSO, IT MAY AFFECT YOUR ELIGIBILITY FOR A STATE OR FEDERAL PROGRAM, SUCH AS MEDICAID, AND BENEFITS MAY BE TAXABLE. YOUR TAX ADVISOR SHOULD BE CONSULTED.

Part I To be completed by Insured (and Spouse, if applying for Dependent Accelerated Benefit) along with the Form W-9 Notice *(on reverse side)*

1. Full name of insured *(Please print.)*	2. Social Security number	3. Date of birth

4. Legal residence *(street, city or town, state, zip code)*

5. Full name of Spouse *(if applying for Dependent Accelerated Benefit)*	6. Social Security number	7. Date of birth

8A. Percentage of amount of life insurance elected _____% *(Subject to the Accelerated Benefit limits set forth in your certificate of insurance.)*	8B. Elected amount of Accelerated Benefit $_____

9. Date illness began	10. Date first consulted physician	11. Describe nature of illness

12. Have you had the same or similar illness before? ☐Yes ☐No If "Yes," please provide dates and details.

13. Name of primary physician(s)	Full address(es)	Date of first and last treatment
Name of hospital(s)	**Full address(es)**	**Date(s) of Confinement**

14. I AUTHORIZE any physician, medical practitioner, hospital, pharmacy, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Union Security Insurance Company, its legal representative or agency employed by the Company, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Union Security Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Union Security Insurance Company EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

I certify to the correctness of these statements.

Insured's signature _____ DATE

Spouse's signature _____ DATE

by _____ IF INSURED OR SPOUSE CANNOT SIGN RELATIONSHIP

(If Power of Attorney, Guardian or Conservator, please forward a certified copy of the court order evidencing your appointment.)

15. **Disclaimer Statement:** I understand that receipt of an Accelerated Benefit may affect my eligibility for a state or federal program, such as Medicaid, and that these benefits may be taxable. Also, I understand that the death benefit will be reduced if I receive an Accelerated Benefit.

_____ INSURED _____ *BENEFICIARY _____ SPOUSE

*Note: If you have designated an irrevocable beneficiary or if you are requesting an Accelerated Benefit in excess of 50% of your amount of life insurance, your beneficiary's signature is required before an Accelerated Benefit can be paid to you.

PAYMENT OF BENEFITS

If the amount of the life insurance you accelerated plus interest exceeds the required minimum, a ProviderFund account will automatically be opened in your name. ProviderFund account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money.

If you are a resident of MS or PA, Assurant Employee Benefits also offers optional payment methods. For a complete discussion of the options available in your state, call your claims representative at **800.451.4531**.

IMPORTANT FORM W-9 NOTICE

Under Federal law every financial institution that pays you interest is required to have you certify 1) your Social Security number *(or other taxpayer identification number)* and 2) whether or not the Internal Revenue Service has notified you that you are subject to Backup Withholding Order on interest and dividends. **It is very important to you** that we have your **Social Security number** *(or other taxpayer identification number)* and **Backup Withholding status** certification.

Although everyone must file a certification like the form below *(if you do not, the IRS can subject you to a $50 penalty)*, you are not subject to a Backup Withholding Order unless you have been so notified by the IRS. If you do not file a certification, the IRS automatically requires all financial institutions to withhold at least 31% of all interest and dividends they credit to your account, and send the money to the IRS as a prepayment of your possible tax liability.

Please **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number *(or other taxpayer identification number)*, it is easy to apply for one at a local Social Security office.

Life Benefit Center
Substitute Form W-9

Certification Form of
Taxpayer Identification Number

Please list your Social Security number _____ *(or other taxpayer identification number).*

I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends. *(If you have been notified, please cross out the portion of the sentence beginning with "2)".)*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Insured's signature _____ Date _____

Please print your name _____

Part II To be completed by employer

1. Full name of insured *(Please print.)*	2. Certificate number	3. Effective date of insurance: A. on insured B. on dependent	4. Date employed

5. Full-time: ☐Yes ☐No Part-time: ☐Yes ☐No	6. Usual number of hours worked per week	7. Date insured ceased working usual number of hours per week	8. Reason insured ceased working

9. Occupation, position or title	10. Basic salary rate as of the policy determination date immediately preceding the date last worked (Please refer to your Group Policy Schedule.) $ per

11. Legal residence *(street, city, town, state)*	12. Employer's name and full address

13A. Full amount of Term Insurance Full amount of Dep. Life Insurance	13B. Date of last increase in the amount of life insurance	14. Accelerated Benefit amount

15A. Due date of last premium paid by or on behalf of insured	15B. Mode of Premium Payment: ☐Monthly ☐Quarterly ☐Semi-annually ☐Annually

16. Group policy no. _____
Group participation no. _____
Account no. _____

Please forward the original application/beneficiary changes (if maintained by the policyholder).

Name of group policyholder _____
Telephone number _____
Name of administrator _____
(if other than policyholder) *Note: Third Party Administrators must also complete a TPA Form KC3508.*
Telephone number _____

17. Have you any additional information relating to this claim?

18. We hereby certify that the above facts are true to the best of our knowledge.

Signature _____ Date _____
AUTHORIZED SIGNATURE OF THE POLICYHOLDER WITH NO FINANCIAL INTEREST IN THE CLAIM

After you have had your Attending Physician complete the Accelerated Benefit Claim Statement—Supplement, pages 5 and 6 of this form, please return to: **Assurant Employee Benefits**, PO Box 973050, El Paso, Texas 79997-3050.

Accelerated Benefit Claim Statement—Supplement

ASSURANT Employee Benefits®

The patient must pay any costs for completion of this form.

Name of patient _____ Date of birth _____

Address _____ Telephone _____
STREET CITY STATE ZIP CODE

Employer's name

Plan, Policy or Participation number

Account number

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, law enforcement agency, or employer having medical information with respect to any physical or mental condition and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

_____ _____
SIGNATURE OF PATIENT DATE

ATTENDING PHYSICIAN'S STATEMENT

History

Patient's symptoms result from: ☐Illness ☐Accident

Date symptoms first appeared _____

Dates of treatment:

Date of first visit for this condition _____

Date of most recent visit _____

Date of most recent comprehensive exam _____

Frequency: ☐Weekly ☐Monthly ☐Other *(Specify.)* _____

Name(s) and address(es) of other treating physician(s)

Hospital name _____ Confinement dates _____ through _____

Address _____
STREET CITY STATE ZIP CODE

Diagnoses

Diagnoses *(including any complications)*

Subjective symptoms

Objective findings *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*

Treatment

Describe treatment program, including any surgery or medications.

Assurant Employee Benefits PO Box 973050 El Paso Texas 79997-3050
T 800.451.4531 F 816.881.8967

Work Capabilities

Are you familiar with the physical and mental demands of the patient's **regular** occupation? ☐Yes ☐No

During what period was the patient **unable** to perform the essential duties of his/her **regular** occupation on a **full-time** basis?

Disability began _____ Ended (or will end) _____ **OR**

☐Never disabled for regular occupation (while under my care) **OR**

☐Disability status unknown

Is patient now able to perform the essential duties of his/her **regular** occupation on a **part-time** basis?
☐Yes ☐No *(If "No," specify which essential job duties the patient is unable to perform.):*

Are you familiar with the patient's education, training, and experience? ☐Yes ☐No

During what period was the patient **unable** to perform **any and every full-time** occupation, in view of his/her training, education, and experience?

Disability began _____ Ended (or will end) _____ **OR**

☐Never disabled for **any and every** occupation (while under my care) **OR**

☐Disability status unknown

Is patient **now** able to perform any work on a **part-time** basis? ☐Yes ☐No

Describe any physical or mental limitations, resulting from this illness/injury, which might interfere with the patient working in **any** occupation.

During what period was the patient affected by these limitations?

Began _____ Ended (or will end) _____ **OR**

☐Unknown

In your opinion, does the claimant possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds? ☐Yes ☐No

Prognosis

Is this patient permanently confined to a nursing home? ☐Yes ☐No ☐Unknown

Nursing home name _____

Address _____
STREET CITY STATE ZIP CODE

Confinement dates _____ through _____

Based upon this patient's medical condition and your current clinical findings, this patient has a Life Expectancy of:

☐Six (6) months or less

☐Six (6) to twelve (12) months

☐Twelve (12) to twenty-four (24) months

☐More than twenty-four (24) months

Name

Physician's name _____ Degree/Specialty _____

Address _____
STREET CITY STATE ZIP CODE

Telephone no. _____ Fax no. _____

Signature _____ Date _____