GREAT-WEST FINANCIAL™

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ACCELERATED BENEFIT REQUEST FORM

Part A. – MEMBER'S STATEMENT (Failure to answer all questions may delay payment)

1. Complete Part A
2. Have your physician complete Part B.
3. Sign and date the form.
4. If an irrevocable beneficiary has been designated previously, his or her signature IS REQUIRED.
5. Mail the completed form and information to the address shown above.

Member's Information:

_____
Name Street Address City State Zip Code

_____ _____
ADA Number Certificate Number

Insured's Information (if other than Member) :

_____
Name Street Address City State Zip Code

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed ☐ Legally Separated

Are you still employed? ☐ Yes ☐ No If **NO**, Date last worked _____/_____/_____ _____
Social Security Number

% of Total Elected for Living Benefit (subject to plan limits) _____

_____ _____ _____ _____/_____/_____
Name of Person Claiming the Accelerated Benefit (if different than member) | Relationship to Member | Social Security Number | Date of Birth

Is all or part of your insurance under this policy subject to a court approved divorce decree, separate maintenance agreement or property settlement agreement? ☐ Yes ☐ No

Have you ever filed Chapter 7 or Chapter 13 bankruptcy? ☐ Yes ☐ No If Yes, date _____/_____/_____

I understand that I must provide satisfactory proof that I have a life expectancy of 24 months or less. I understand that any Accelerated Benefit that I receive may be treated as taxable income and it is recommended that I consulting with my personal tax and/ or legal advisor before applying for the Accelerated Benefit. I also understand that the Accelerated Benefit is subject to the limits outlined in my Certificate(s) and can only be paid once. If the Accelerated Benefit is paid and the amount is equal to or greater than the amount of my Life Insurance in force at the time of my death, I understand that no additional amounts of Life Insurance will be payable to my beneficiary.

I authorize all physicians and other persons who have attended the insured and all hospitals, institutions, government authorities, and other insurance companies to furnish to Great-West all information in their possession or within their knowledge respecting the insured and to honor a photostatic copy of this authorization.

_____ _____
Signature of Person Claiming the Accelerated Benefit (or a person with legal Authority if the insured is legally incapacitated – provide copy of POA document) | Date

_____ _____
Signature of Spouse (if applicable) | Date

_____ _____
Signature of Owner, if other than the Member | Date

_____ _____
Signature of Collateral Asignee (if one has been designated) | Date

_____ _____
Signature of Irrevocable Life Beneficiary (if one has been designated) | Date

Please also have Part B on reverse page completed.

Part B. – PHYSICIAN'S STATEMENT (Complete and return to patient)

1. Complete Part B.
2. Sign and date the form.
3. Return the form and information to the insured

IMPORTANT: Be sure to include all medical test results, laboratory reports and any other information on which the diagnosis is based including the protocol used to determine the insured's expected remaining life span.

_____ _____

Physician's Name **Street Address** **City** **State** **Zip Code**

(_____)_____ _____ _____ _____

Telephone Number **Tax ID Number** **Date first consulted for condition** **Name of Referring Physician**

Diagnosis or Nature of Illness (Please attach all medical test results, laboratory reports and any other information on which the diagnosis is based including the protocol used to determine the insured's expected remaining life span.):

_____
_____
_____
_____
_____
_____

ICD Diagnosis Code _____ **Life expectancy of insured (# of months)** _____

I certify that I am a currently licensed Physician and the insured is terminally ill with the life expectancy stated above. I also certify that I am not the insured. I do not live with the insured and I am not a member of the insured's immediate family (parent, spouse, sibling or child).

_____ _____

Signature of Physician **Date**

Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.