

ACCELERATED BENEFITS CLAIM FORM

POLICY NUMBER(S) _____ AMOUNT OF ACCELERATED BENEFIT 30% 60%

FULL NAME OF INSURED _____ SSN _____

RESIDENCE ADDRESS OF INSURED _____

HOME NUMBER _____ WORK NUMBER _____ CELL NUMBER _____

DATE OF BIRTH OF INSURED _____ PLACE OF BIRTH _____

CURRENT OCCUPATION _____ DATE LAST WORKED _____

WHEN DID YOU FIRST COMPLAIN OR GIVE OTHER INDICATIONS OF THIS ILLNESS?

NAME/ADDRESSES OR PHONE NUMBERS OF ALL PHYSICIANS OR PRACTITIONERS THAT YOU CONSULTED:

NAMES/ADDRESSES	PHONE NUMBER	DATE OF ATTENDANCE	DISEASE OR CONDITION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The statements above are true and complete. Any physician or practitioner who has attended _____, the Insured, and/or any hospital (including Veterans Administration Hospital) or other institution in which the Insured was treated or confined, is hereby authorized to furnish to Leaders Life Insurance Company or its representatives, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions or treatments pertaining to the Insured. *I further understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).*

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

INSUREDS SIGNATURE _____ **DATE** _____

If the named insured is so incapacitated to be unable to sign this form, next of kin or person with current power of attorney must sign and the form must be notarized.

DATED AT _____ THIS _____ DAY OF _____,

STATE OF _____)

COUNTY OF _____)

On this _____ day of _____, _____ personally appeared before me the above named _____ who is known to me and who subscribed the foregoing statement before me and made oath that the foregoing answers are each and all complete and true.

Signature _____

My Commission Expires _____