___ American-Amicable Life Insurance Company of Texas ___ IAAmerican Life Insurance Company
___ Pioneer American Insurance Company ___ Pioneer Security Life Insurance Company
___ Occidental Life Insurance Company of North Carolina
___Industrial Alliance Insurance and Financial Services, Inc.

P.O. Box 2549, Waco, TX 76702, 800-736-7311

POL NO._____

CONFINED CARE CLAIM FORM

PART ONE: TO BE COMPLETED BY INSURED/POLICYOWNER

Please Note: Failure to complete this form IN FULL may delay payment of your claim. PLEASE PRINT.

1. Insured's Name: _____2. Insured's Date of Birth: _____
3. Policy owner/Certificate Holder: _____
4. Policy owner/Certificate Holder's Mailing Address: _____

_____

5. Enter your taxpayer identification number. For most individuals this is your social security number_____

CERTIFICATION – Under penalties of perjury I certify that:
1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Policy owner/Certificate Holder's Signature: _____

6. Admitting Diagnosis: _____

7. Date of Admission to Facility:_____

8. When was the condition first diagnosed? _____

9. Is your physician a member of the Insured's/Owner's immediate family? ____yes ____ no If yes, state your relationship.

_____

10. Does the physician reside with the Accelerated Benefit insured or owner? ____ yes ____ no

11. First doctor consulted and date(s) of treatment: _____

Date:_____

All other doctors consulted and date(s) of treatment:

Name: _____ Name: _____ Name: _____

Address: _____ Address: _____ Address: _____

_____ _____ _____

Date: _____ Date: _____ Date: _____

Date: _____

Signature of Patient/guardian/personal representative_____

Legal relationship to applicant: _____

Part Two ATTENDING PHYSICIAN REPORT

Patient's Name: _____Age: _____

ACCELERATED CONFINED CARE BENEFIT

1. Admitting Diagnosis: _____

_____

2. Onset Date: _____

3. First Consulted You on: _____

4. Other Diagnoses Treated in the Past Two Years

_____Date _____

_____Date _____

_____Date _____

5. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days? __ yes __ no

If YES, expected period of illness: _____

6. Does patient require continual medical supervision? __yes __ no

If No, explain: _____

7. Was patient referred to you by another physician? __ yes __ no
If YES, give name and address of referring physician.

_____
(Name of referring physician) (Address) (Area Code/Phone Number)

Date _____ Signed _____
(Fed Tax ID No.)

Name of attending physician (Please print) _____

_____
(Street Address) (State/Zip Code) (Area Code/Phone Number)

Part Three: To be completed by the Director of Nursing

Policy Number: _____

Patient's Name: _____ Social Security No. _____

1. Date of admission to this facility: _____

2. Is the patient a full time permanent resident? _____

3. Is the facility Medicare-approved skilled Nursing Facility? _____

4. What type of care are you licensed to Provide? _____

   License Number: _____

   __Skilled __Intermediate __Custodial __Personal __Assisted Living __Residential __Respite __Other

5. Are you state licensed as a Nursing Home? __ yes __ no
   Primarily provide nursing care? __ yes __ no
   Provides supervision by a registered or licensed practical nurse? __ yes __ no
   Keep daily patient medical records? __ yes __ no
   Record and control all medications? __ yes __ no

6. Describe the type of care administered. _____
   _____

7. Admitting Diagnosis: _____
   _____

8. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days? __ yes __ no

If YES, expected period of illness: _____

9. Was patient confined to another facility or hospital prior to this admission? __yes __ no

If YES, give name and address of facility and dates of confinement:

Facility _____ Date _____

Facility _____ Date _____

_____
Signature of Director of Nursing Date

Name of Director of Nursing (Please Print)_____

Name of Institution _____ Tax ID Number _____

Address _____ Phone Number ( ) _____

_____

Important Notice

In some states we are required to advise you of the following: Any person, who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

Colorado – 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

District of Columbia – 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.

Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana – 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.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts – 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 state prison.

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico – 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 civil fines and criminal penalties.

Oklahoma – 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.

Pennsylvania – 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.

Puerto Rico – Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Rhode Island – 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.

Tennessee – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia – Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

In All Other States – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing a false or deceptive statement may be guilty of insurance fraud.