☐ American-Amicable Life Insurance Company of Texas • Email: Claims@AmericanAmicable.com
☐ IA American Life Insurance Company • Email: Claims@IAAmerican-Waco.com
☐ Industrial Alliance Insurance and Financial Services Inc. • Email: Claims@IAPlife-Waco.com
☐ Pioneer American Insurance Company • Email: Claims@PioneerAmerican.com
☐ Pioneer Security Life Insurance Company • Email: Claims@PioneerSecurityLife.com
☐ Occidental Life Insurance Company of North Carolina • Email: Claims@OccidentalLife.com

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

ACCELERATED LIVING BENEFIT CLAIM FORM

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: _____ Sex: ☐ Male ☐ Female
2. Insured's Date of Birth: Mo:_____Day:_____ Year: _____
3. Policy/Certificate No.: _____
4. Policyowner/Certificate Holder:_____
5. Policyowner/Certificate Holder's Mailing Address: _____
   _____
6. Policyowner/Certificate Holder's Signature: _____

7. 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.

   Policyowner/Certificate Holder's Signature: _____ Date:_____

8. Diagnosis (Covered Condition):_____
9. Date Symptoms First Noticed:_____
10. When was the covered condition first diagnosed? _____
11. Is your physician a member of the Insured's/Owner's immediate family? ☐ Yes ☐ No If yes, state your relationship:
    _____
12. Does the physician reside with the Accelerated Benefit insured or owner? ☐ Yes ☐ No

13. First doctor consulted and date(s) of treatment:
    Name:_____ Date:_____
    Address:_____
    All other doctor's consulted and date(s) of treatment:

Name:_____	Name:_____	Name: _____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Date:_____	Date:_____	Date:_____

CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical, professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, government agency including, but not limited to, the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agents, or legal representative, and any insurance support organization and consumer reporting agency acting on the The Company's behalf, with any and all medical records and personal information requested about me or my minor children.

I UNDERSTAND that this Authorization will be used to obtain information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use of drugs or use of alcohol.

I UNDERSTAND the information obtained by use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy.

I KNOW that I or my legal representative may request to receive a copy of this Authorization.

I UNDERSTAND that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization at any time by requesting such in writing to the Company at the address shown above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date:_____

Signature of Patient/guardian/personal representative: _____

Legal relationship to applicant: _____

(Only if signed above by guardian or personal representative)

PART II ATTENDING PHYSICIAN REPORT

PATIENT'S NAME:	AGE:

ACCELERATED LIVING BENEFIT

An Accelerated Benefit is the payment of a portion of the Eligible Face Amount before the Insured's death. If the Insured has a qualifying event, we will pay an Accelerated Benefit in the amount requested by the Owner, subject to the provisions of this endorsement.

If the qualifying event is a terminal illness, the patient must have a life expectancy of twelve months or less. In your estimation, does your patient meet this requirement?

☐ no
☐ yes, my patient has a life expectancy of twelve months or less. Estimated number of months _____

1. DIAGNOSIS & PROGNOSIS	
2. HISTORY (a.) When did symptoms first appear or accident happen?	Mo. _____ Day _____ Year _____
3. PRESENT CONDITION (a) Subjective symptoms (b) Objective findings (Include results of current X-rays, E.K.G.s, all other special tests) (c) Is patient:	Is the patient mentally capable of handling his/her own affairs? ☐ Yes ☐ No If No, is there a legal guardian? _____ ☐ Ambulatory? ☐ Bed Confined? ☐ House Confined? ☐ Hospital Confined?
4. TREATMENT (a) Date of first visit (b) Date of last visit (c) Frequency of visits When did you last examine the patient?	 Mo._____ Day _____ Year _____ Mo._____ Day _____ Year _____ ☐ Weekly ☐ Monthly ☐ Other _____ Mo._____ Day _____ Year _____
5. If patient hospitalized, give name and address of hospital. Hospital _____ City and State _____ Admitted _____ Discharged _____	Give names and addresses of all doctors treating your patient.

It would be helpful to our evaluation of this claim to include a copy of the most recent hospital summary and office notes.

NOTE: _____ANY CHARGE FOR THESE RECORDS MUST BE THE RESPONSIBILITY OF THE INSURED.

Physician's signature Date Telephone number

Physician's printed name

Street Address City State Zip Code

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.

Arizona – "For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.