P.O. Box 100102
Columbia, SC 29202-3102

Claim for Accelerated Benefits

(TO AVOID DELAY PLEASE ANSWER ALL QUESTIONS)

PLEASE PRINT

EMPLOYEE

1. FULL NAME (Last, First) SOCIAL SECURITY NUMBER

2. ADDRESS CITY STATE ZIP PHONE NUMBER ( )

3. DATE OF BIRTH (Mo. Day Yr.) SEX ☐ Male ☐ Female

4. OCCUPATION (List the duties of your occupation at the time of disability) ( )

5. MARITAL STATUS
☐ Single ☐ Married ☐ Widowed ☐ Divorced
In community property states, written consent of the spouse will be required when applying for Accelerated Benefits.

6. I have been unable to work because of this disability since:
Mo. __________ Day _________ Yr. _________

7. Date of your accident or the date you first noticed the symptoms of your illness: Mo. __________ Day _________ Yr. _________

8. Describe how and where accident occurred or describe the first symptoms of your illness

____

9. Date you were first treated for your illness or injury
____
(Mo. Day Yr.)

Treated By: Hospital ________________ Name Address
Doctor ________________ Name Address

10. Have you ever had the same or similar condition in the past?
☐ Yes ☐ No
____
(Mo. Day Yr.)

Treated By: Hospital ________________ Name Address
Doctor ________________ Name Address

11. BENEFICIARY INFORMATION

NAME OF BENEFICIARY	RELATIONSHIP	TELEPHONE	DATE OF BIRTH OF BENEFICIARY
ADDRESS OF BENEFICIARY (STREET, CITY, STATE, and ZIP CODE)			SOCIAL SECURITY NUMBER

FRAUD WARNING: (not applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING: (FL only): 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.

12. SPOUSAL CONSENT – Must be signed by spouse if employee is residing in a community property state.
I hereby acknowledge and give my consent for application of the Accelerated Benefits.

DATE ____________________ SIGNATURE OF SPOUSE ____________________

13. An interest bearing money market account (Insured Benefit Account) will be opened for you at State Street Bank and Trust Company, Boston, Massachusetts. Upon approval for payment of the benefits, you will promptly receive personalized checks and may **immediately** utilize all or a portion of those funds by writing checks against the account. The funds in the account, meanwhile will earn interest at a competitive variable rate and will be insured for the full amount permitted by the FDIC. And, there are no monthly fees or service charges associated with the account. By signing below, you instruct Companion Life to transfer the settlement proceeds to State Street Bank and Trust Company and you authorize State Street Bank and Trust Company to obtain any references necessary, and to exchange information with Companion Life concerning your Insured Benefit Account. For a current quote on the interest being paid thereon, or for additional information regarding this or any other settlement option call (206) 670-4575.

UNDER PENALTIES OR PERJURY: I certify (1) that the number shown on this form is my correct taxpayer identification number, and (2) that I am not subject to backup withholding as a result of a failure to report all interest or dividend, or that the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (If subject to backup withholding please cross out No. 2.)

The above Statement are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agent to furnish the Insurance Company providing this form, or their representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Date ____________________ Signature of Employee **X** ____________________