

**Phone Number:** (800) 778-2281  
**Fax:** (630) 824-5419

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## INSTRUCTIONS

Your Life Insurance policy allows you to apply for an accelerated benefit paid to you during your lifetime if you are determined to have a terminal illness. This benefit is an advance payment of a portion of your Life Insurance, up to the maximum amount indicated in your Life Insurance policy. If your claim is approved and payment is made to you, the amount of your Life Insurance under the Group Policy will be reduced by the Benefit paid.

To apply, the Claim packet should be completed in full. Each entry is important and must be completed to avoid delay in processing your claim. If an information block does not apply or if information is not available, please write "none" in the space provided. If a form is incomplete, it will be returned. PLEASE PRINT.

To be eligible for this Benefit, you must meet the following conditions:

- Be insured for Life Insurance under the Group Policy at the time you apply and receive this benefit.
- Provide us with satisfactory written proof from a medical professional that you have a terminal illness.

Please note that you can receive this benefit **only once**.

Your claim packet consists of:

### **Section 1, Parts A & B, Employee Statement**

Section 1, parts A & B are to be completed by the Employee and returned to the Employer to be sent to Fort Dearborn Life Insurance Company. Remember to sign and date each Statement. Your signature enables Fort Dearborn Life Insurance Company to obtain the information necessary to determine your eligibility for this benefit. You may request a copy of this authorization.

### **Section 2. Employer Statement**

To be completed by the Employer and returned to Fort Dearborn Life Insurance Company along with Section 1. Sections 1 & 2 should be sent to Fort Dearborn Life Insurance Company as soon as they are completed, and the Attending Physician Statement can be sent at a later date.

### **Section 3, Attending Physician Statement**

To be completed by the Employee's Physician. If you have more than one Physician for your condition, a statement should be completed by each Physician. The completed section of the claim form should be returned to:

Fort Dearborn Life Insurance Company  
Attention Claims Department  
1020 31st Street  
Downers Grove, IL 60515-5591

The Employee is responsible for ensuring that all required portions of the claim form are completed and returned to Fort Dearborn Life Insurance Company. Contact Fort Dearborn Life Insurance Company at 1-800-348-4510 for any questions or assistance regarding this claim form packet.

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**SECTION 1 - PART A – TO BE COMPLETED BY THE EMPLOYEE**

**Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or that of your spouse or dependents.**

**Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.**

No health care facility as defined in Section 20 of the Public Health Law can require you to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Fort Dearborn Life Insurance Company is prohibited from paying accelerated death benefits to you for a period of 14 days from the date of your application for an Accelerated Death Benefit.

This application is voluntary and without coercion on the part of any third party.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Print Name \_\_\_\_\_

Your spouse is required to sign this request if you reside in one of the Following Community Property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin.

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Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

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Print Name \_\_\_\_\_

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**SECTION 1 PART B – TO BE COMPLETED BY THE EMPLOYEE**

Claimant's Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Maiden Name \_\_\_\_\_

1. Date of accident or beginning of sickness: \_\_\_\_\_

2. Are you still working?  Yes  No If No, Date last worked: \_\_\_\_\_

3. Nature of injury or illness: \_\_\_\_\_  
 \_\_\_\_\_

4. If injury, describe how, when and where accident occurred: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever had a similar illness?  Yes  No If yes, give dates: From \_\_\_\_\_ To \_\_\_\_\_

6. Name of Hospital(s) - Attach separate page if necessary: \_\_\_\_\_

Dates confined: From \_\_\_\_\_ To \_\_\_\_\_

Address of Hospital(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Name and address of Doctor(s)- Attach separate page if necessary: \_\_\_\_\_  
 \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

8. If benefits are being claimed for a dependent spouse or child, complete the following:

Dependent Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Relationship \_\_\_\_\_

9. Fort Dearborn Life Insurance Company benefits being claimed:

Amount Life Insurance Inforce \$ \_\_\_\_\_

Amount of Benefit Requested \$ \_\_\_\_\_

Remaining Life Insurance \$ \_\_\_\_\_

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**Method of Payment**

**Dearborn National Freedom Account\***

If your benefit payment is scheduled to be \$10,000 or more, Dearborn National will establish an interest bearing checking account in your name, unless you have requested otherwise. The Dearborn National Freedom Account is a safe and secure interest bearing checking account into which life proceeds are deposited. With the Dearborn National Freedom Account you are able to earn a competitive rate of interest on the life insurance proceeds while taking your time to weigh the important financial decisions that often follow a life changing event. The Dearborn National Freedom Account provides you immediate access to your benefit funds. The benefits of the account include:

- Flexibility** – During this stressful time you are given the flexibility and time to make important financial decisions and decide the best options for your financial future.
- Security** – All amounts are fully protected and guaranteed by Fort Dearborn Life Insurance Company.
- Free** – As long as your account remains open, you will receive monthly statements and have access to unlimited free checks.
- Accessibility** – You can write checks for any amount of \$250.00 or more to use as you wish.
- Interest** – Your account will earn interest beginning on the day it is opened. Interest is compounded daily and credited to your account each month. Your monthly statements will provide additional details on your balance.

Once your claim is approved, you will receive a checkbook and an implementation kit within 72 hours explaining the benefits of the Dearborn National Freedom Account. Once established, you will have access to 24 hour customer service.

Your implementation kit will contain the following:

- Copy of the required Privacy Letter outlining the steps we take to ensure your privacy.
- A detailed booklet containing information and frequently asked questions on the Dearborn National Freedom Account and how it works.
- A confirmation certificate containing information on your account and the benefit amount that was placed into the account.

\*Not available in Alaska or Kansas

**Certification**

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) 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 (c) the IRS notified me that I am not longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

**The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

NOTE: Your signature as signed above will also be used to verify your signature for Dearborn National Freedom Account checks, if applicable.

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**Section 2 : EMPLOYER'S/PLAN ADMINISTRATOR'S STATEMENT**

Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Hire Date \_\_\_\_\_ Insurance Effective Date \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's E-mail address: \_\_\_\_\_ Employer's Group Number \_\_\_\_\_

Last Day Worked \_\_\_\_\_ Date returned \_\_\_\_\_ Base Annual Salary \_\_\_\_\_

Hours worked per week \_\_\_\_\_ Workers' Comp Claim filed? \_\_\_\_\_

Employee's Occupation \_\_\_\_\_

Premium Contribution by Employer \_\_\_\_\_% Employee \_\_\_\_\_% Employee Contribution pre-tax?  Yes  No

Amount of Life Insurance Inforce: \_\_\_\_\_

**If injured party is a dependent spouse or child, complete the following:**

Dependent's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Relationship to Employee \_\_\_\_\_

Fort Dearborn Life Insurance Company Benefits being claimed

Amount Life Insurance Inforce \$ \_\_\_\_\_

Amount of Benefit Requested \$ \_\_\_\_\_

Remaining Life Insurance \$ \_\_\_\_\_

**I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.**

Signature of Authorized Employer/Plan Representative \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

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**Section 3 – Attending Physician’s Statement**

Dear Doctor:

The purpose of this report is to assist us in evaluating the patient’s claim for payment of an accelerated life insurance benefit for terminal illness. In completing this report, please include sufficient details of history, physical or diagnostic findings, clinical course, therapy and response to therapy so that we are able to complete our evaluation.

THE PATIENT IS RESPONSIBLE FOR ANY EXPENSE INVOLVED IN THE COMPLETION OF THIS FORM.

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

EMPLOYEE NAME IF OTHER THAN PATIENT \_\_\_\_\_

**DIAGNOSIS**

Date of last examination \_\_\_\_\_

Diagnosis (including any complications) \_\_\_\_\_

\_\_\_\_\_

ICD-9 Code(s) \_\_\_\_\_

Please submit, with completed form, copies of all objective findings (including current test findings, x-ray reports, EKG’s, Laboratory Data and clinical findings.)

**HISTORY**

When did the symptoms first appear or accident happen? \_\_\_\_\_

Date first seen for this condition \_\_\_\_\_ Was patient referred by another physician?  Yes  No

Referring physician’s name and contact information \_\_\_\_\_

\_\_\_\_\_

**NATURE AND DATES OF TREATMENT** (Including medications prescribed)

\_\_\_\_\_

\_\_\_\_\_

**SURGICAL PROCEDURES AND DATES**

If confined to a hospital or other facility, provide name, address and dates of confinement: \_\_\_\_\_

\_\_\_\_\_

**PROGNOSIS**

Have you diagnosed this patient as terminally ill?  Yes  No

Date first diagnosed as terminally ill: \_\_\_\_\_ Anticipated Life Expectancy \_\_\_\_\_

Physician Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical and psychological reports; records, charts, notes – excluding psychotherapy notes -, x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Fort Dearborn Life Insurance Company  
1020 31st Street  
Downers Grove, IL 60515
- I understand the information obtained by use of this Authorization will be used by Fort Dearborn Life Insurance Company (The Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As otherwise may be required by law or as I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent;
  - The Company has taken action in reliance on this Authorization; or
  - The Company is using this Authorization in connection with a contestable claim.

If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the company at the above address.

- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Print Name: \_\_\_\_\_

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO. \_\_\_\_\_

Street

City

State

Zip

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**The laws of some states require us to furnish you with the following notice:****FOR APPLICATIONS AND CLAIMS:**

**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.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Kentucky:** 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 a fraudulent insurance act, which is a crime.

**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.

**Maine & 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.

**Maryland:** Any person who knowingly and willingly 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.

**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.

**Ohio:** Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing 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 intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars(\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, 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:** 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.

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The laws of some states require us to furnish you with the following notice:

**FOR CLAIMS ONLY:**

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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.

**Arkansas:** 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.

**California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FOR APPLICATIONS ONLY:**

**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 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.