

**Accelerated Death Benefit Claim Statement—
Insured/Spouse**



IMPORTANT NOTICE: 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. 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 the eligibility of your spouse or dependents. Receipt of Accelerated Death Benefits may be taxable. Your tax advisor should be consulted.

Part I To be completed by Insured (and Spouse, if applying for Dependent Accelerated Death Benefit) along with the Form W-9 Notice (on reverse side)

1. Full name of insured (<i>Please print.</i>)	2. Social Security number	3. Date of birth
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4. Legal residence (*street, city or town, state, zip code*)

5. Full name of Spouse (<i>if applying for Dependent Accelerated Death Benefit</i>)	6. Social Security number	7. Date of birth
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8A. Percentage of amount of life insurance elected _____ % (<i>Subject to the Accelerated Death Benefit limits set forth in your certificate of insurance.</i>)	8B. Elected amount of Accelerated Death Benefit \$ _____
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9. Date illness began	10. Date first consulted physician	11. Describe nature of illness
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12. Have you had the same or similar illness before? Yes No If "Yes," please provide dates and details.

13. Name of primary physician(s)	Full address(es)	Date of first and last treatment
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Name of hospital(s)	Full address(es)	Date(s) of Confinement
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14. I AUTHORIZE any physician, medical practitioner, hospital, pharmacy, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Union Security Life Insurance Company of New York, its legal representative or agency employed by the Company, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Union Security Life Insurance Company of New York to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Union Security Life Insurance Company of New York EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

15. My application for Accelerated Death Benefits is voluntary and without coercion on the part of any third party.

16. I understand that no health care facility as defined in Section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health facility or for providing any care in such facility.

17. The death benefit paid to my beneficiary will be reduced if I receive the Accelerated Death Benefit.

18. The insurer is prohibited from paying any Accelerated Death Benefit for 14 days from the date on which the information specified in Section 41.4(e) of Regulation 143 is transmitted in writing to me.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I certify to the correctness of these statements. Insured's signature _____ DATE

Spouse's signature _____ DATE

by _____

IF INSURED OR SPOUSE CANNOT SIGN

RELATIONSHIP

(*If Power of Attorney, Guardian or Conservator, please forward a certified copy of the court order evidencing your appointment.*)

Irrevocable Beneficiary's signature _____ DATE

(*If you have designated an irrevocable beneficiary, your beneficiary's signature is required before an Accelerated Death Benefit can be paid to you.*)

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.

Union Security Life Insurance Company of New York

Administered by: **Assurant Employee Benefits** PO Box 419244 Kansas City Missouri 64141-6244

T 800.451.4531 F 816.881.8967

PAYMENT OF BENEFITS

If the amount of the life insurance you accelerated plus interest exceeds the required minimum, an Insured Benefit Account will automatically be opened in your name. Insured Benefit Account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money.

IMPORTANT FORM W-9 NOTICE

Under Federal law every financial institution that pays you interest is required to have you certify 1) your Social Security number (or other taxpayer identification number) and 2) whether or not the Internal Revenue Service has notified you that you are subject to Backup Withholding Order on interest and dividends. **It is very important to you** that we have your **Social Security number** (or other taxpayer identification number) and **Backup Withholding status** certification.

Although everyone must file a certification like the form below (if you do not, the IRS can subject you to a \$50 penalty), you are not subject to a Backup Withholding Order unless you have been so notified by the IRS. If you do not file a certification, the IRS automatically requires all financial institutions to withhold at least 31% of all interest and dividends they credit to your account, and send the money to the IRS as a prepayment of your possible tax liability.

Please **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number (or other taxpayer identification number), it is easy to apply for one at a local Social Security office.

**Life Benefit Center
Substitute Form W-9**

**Certification Form of
Taxpayer Identification Number**

Please list your Social Security number _____ (or other taxpayer identification number).

I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends. (If you have been notified, please cross out the portion of the sentence beginning with "2").

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

Insured's signature _____ Date _____

Please print your name _____

Part II To be completed by employer

1. Full name of insured (Please print.)		2. Certificate number	3. Effective date of insurance: A. on insured B. on dependent	4. Date employed
5. Full-time: <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time: <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Usual number of hours worked per week	7. Date insured ceased working usual number of hours per week	8. Reason insured ceased working	
9. Occupation, position or title		10. Basic salary rate as of the policy determination date immediately preceding the date last worked (Please refer to your Group Policy Schedule.) \$ _____ per		
11. Legal residence (street, city, town, state)		12. Employer's name and full address		
13A. Full amount of Term Insurance Full amount of Dep. Life Insurance		13B. Date of last increase in the amount of life insurance	14. Accelerated Death Benefit amount	
15A. Due date of last premium paid by or on behalf of insured		15B. Mode of Premium Payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually		
16. Group policy no. _____ Group participation no. _____ Account no. _____		Name of group policyholder _____ Telephone number _____ Name of administrator _____ (if other than policyholder) Note: Third Party Administrators must also complete a TPA Form KC3508. Telephone number _____		

Please forward the original application/beneficiary changes (if maintained by the policyholder).

17. Have you any additional information relating to this claim? _____

18. We hereby certify that the above facts are true to the best of our knowledge.

Signature _____ Date _____
AUTHORIZED SIGNATURE OF THE POLICYHOLDER WITH NO FINANCIAL INTEREST IN THE CLAIM

After you have had your Attending Physician complete the Accelerated Death Benefit Claim Statement—Supplement, pages 3 and 4 of this form, please return to: **Union Security Life Insurance Company of New York,**
c/o **Assurant Employee Benefits,** PO Box 419244, Kansas City, Missouri 64141-6244.



The patient must pay any costs for completion of this form.

Name of patient _____ Date of birth _____

Address _____ Telephone _____
STREET CITY STATE ZIP CODE

Employer's name	I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, law enforcement agency, or employer having medical information with respect to any physical or mental condition and other non-medical information of me to give to Union Security Life Insurance Company of New York, or its representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Life Insurance Company of New York to determine eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.
Plan, Policy or Participation number	
Account number	

SIGNATURE OF PATIENT

DATE

ATTENDING PHYSICIAN'S STATEMENT

History	Patient's symptoms result from: <input type="checkbox"/> Illness <input type="checkbox"/> Accident
	Date symptoms first appeared _____
	Date of treatment:
	Date of first visit for this condition _____
	Date of most recent visit _____
	Date of most recent comprehensive exam _____
	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (<i>Specify.</i>) _____
Name(s) and Address(es) of other treating physician(s)	
Hospital name _____ Confinement dates _____ through _____	
Address _____ <small>STREET CITY STATE ZIP CODE</small>	
Diagnoses	Diagnoses (<i>including any complications</i>)
	Subjective symptoms
	Objective findings (<i>Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.</i>)
Treatment	Describe treatment program, including any surgery or medications.

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