



Accelerated Benefit Claim Form

Return to: NCM Life Insurance Co.
411 West Chapel Hill Street
Durham, NC 27701
Attn: Sharon Lee

PART I – EMPLOYER/POLICYHOLDER SECTION – Complete			
Name & Address of Employee		Group Policy Account Number	
		Claim Suffixes	<input type="checkbox"/> Basic <input type="checkbox"/> Voluntary
Employee Date of Birth (Mo/Day/Yr) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Name & Address of Policyholder	
Occupation of Employee		Amount of Insurance in Force \$	<input type="checkbox"/> Basic <input type="checkbox"/> Voluntary
Annual Salary		Amount of Benefit Payment (Basic) \$	<input type="checkbox"/> Basic <input type="checkbox"/> Voluntary
Date of Illness (Mo/Day/Yr)	Date Last Reported to Work	Duration of Employment From: To:	
Name of Beneficiary	Relationship to Insured	Beneficiary Date of Birth	
Is the current beneficiary Irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include beneficiary signature authorizing the accelerated benefit payments.		Are there any assignments attached to the policy? If so, please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Beneficiary if Applicable		Explanation	
Send Check To:		Signature of Employer Representative	
		Telephone Number	Date

I AUTHORIZE any physician, hospital or other medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me, my dependents, or our health, to disclose, whenever requested to do so by North Carolina Mutual Life Insurance Company or its representatives, any and all such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I KNOW it is a crime to complete this form with information I know is false or to omit any facts I know are important.

I UNDERSTAND that the receipt of accelerated death benefits may be taxable, and assistance should be sought from a personal tax advisor.

I UNDERSTAND that receipt of accelerated death benefits may affect eligibility for public assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for accelerated death benefits, I should consult with the appropriate social services agency concerning how receipt will affect my eligibility or my dependents'.

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 a facility or for providing any care in such facility.

I SUBMIT this claim voluntarily and without coercion on the part of any third party.

Employee Signature	Date
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**NORTH CAROLINA MUTUAL
LIFE INSURANCE COMPANY**

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name		Age	Sex
Diagnosis and nature of illness or injury			
Date of Illness (First symptom) or injury (Accident)	Date first consulted you for this condition	Has patient ever had a same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of total disability	Name and address of referring physician		
For services related to hospitalization give hospitalization dates		Name and address of hospital	
Admitted:	Discharged:		
What is the life expectancy of the patient?		When was the life expectancy determined?	
Physician's Address		Phone Number	
Signature			Date