



BEST Life and Health Insurance Company

P.O Box 19721, Irvine, CA 92623-9721
(800) 433-0088 • (949) 222-1004 fax
www.bestlife.com

Accelerated Group Term Life Benefits

INSURED'S INFORMATION
Form with fields for: Name of Insured Employee, Employee's Job Title, Date of Employee's Birth, Address of Employee, City, State, Zip, Phone Number, Group Policy No., Certificate No., Amount of Life Insurance, Name and Address of Group Policyholder, Name and Address of Employer, Type of Employment, Hours Worked Per Week, Weekly Earnings, Duration of Employment, Insurance Class, Disability Benefits were Paid, Carrier's Name, Date of premium payments, Last day of full time active work, Reason for stopping work, and Send correspondence and check to.

Signature of Policyholder's Official
Representative X

Date:

Print Name of Signature Above

Telephone
Number:

THE ORIGINAL ENROLLMENT CARD OR APPLICATION FOR INSURANCE SHOULD ACCOMPANY THIS FORM, IF MAINTAINED BY THE POLICYHOLDER.

BY FURNISHING THIS BLANK INVESTIGATING CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY.

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED CRIME.



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Accelerated Group Term Life Benefits Attending Physician's Statement

The patient is responsible for the completion of this form without expense to the Company.

INSURED'S INFORMATION				
Name of Patient		Date of Birth		Group Policy No.
Address of Employee		City	State	Zip Phone Number
HISTORY				
1. When did symptoms first appear or accident happen? Provide Date		2. Has patient ever had same or similar condition? If yes, state when and describe.		
3. Names and addresses of other treating physicians				
DIAGNOSIS				
1. Diagnosis (including any complications)				
2. Subjective symptoms				
3. Objective findings (including current X-rays, EKG's, Laboratory data and any clinical findings)				
DATES OF TREATMENT				
1. Date of first visit	2. Date of last visit		3. Frequency	
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:	
NATURE OF TREATMENT (including surgery and medications if prescribed)				
PROGRESS				
1. Patient has		2. Patient is		
<input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		<input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined		
3. Has patient been hospital confined? If yes, give name and address of Hospital		4. If patient has been confined, please provide the dates of confinement.		
		Confined from through		

PLEASE COMPLETE THE REVERSE

CARDIAC (if applicable)		
1. Functional Capacity (American Heart Association)		2. Blood Pressure (last visit)
<input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 2 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation)		Systolic Diastolic
PROGNOSIS		
1. Is patient's condition terminal?	2. If "yes", what is patient's life expectancy?	3. If patient's condition is not terminal, what is prognosis for recovery?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Years Months	
4. Dates of total disability for patient's job		5. Dates of total disability for any other work
From Through		From Through
MENTAL CAPACITY		
1. Do you believe the patient is competent to make financial decisions, endorse checks and direct the use of proceeds thereof?		2. If "no", please comment on patient's mental capacity
<input type="checkbox"/> Yes <input type="checkbox"/> No		
REMARKS		

Name of attending physician (please print) Degree/specialty Telephone Number

Street Address City State ZIP

Signature **X** Date

- PLEASE ATTACH COPIES OF ANY ADDITIONAL REPORTS OR OTHER MEDICAL INFORMATION THAT MAY ASSIST IN THE EVALUATION OF THE PATIENT'S CLAIM FOR AN ACCELERATED GROUP LIFE INSURANCE BENEFIT.
- TO AVOID UNNECESSARY DELAY IN PROCESSING YOUR PATIENT'S CLAIM FOR BENEFITS, PLEASE COMPLETE ALL BLANK AREAS AND SIGN FORM.

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Accelerated Group Term Life Benefits
Request for Payment

Please print all information requested.

INSURED'S INFORMATION
Name of Insured Employee
Address of Employee City State Zip Phone Number
Name of Group Policyholder Group Policy No. Certificate No. Certificate Effective Date
Life Insurance Amount in Effect prior to receipt of accelerated benefit Life Insurance Amount in Effect after receipt of accelerated benefit

I am requesting the payment of an accelerated benefit amount for which I am eligible in accordance with the terms of the Group Life Accelerated Benefits Rider which is attached to my certificate.

I understand that the accelerated benefit amount for which I am eligible will be discounted to reflect the cost of providing the benefit to me.

NOTICE

You have the right to rescind the request for an accelerated benefit at any time during the process of the application for such benefit.

DECLARATION

- 1. I understand that my request for payment of an accelerated benefit could affect me in the various ways set forth in the Group Life Accelerated Benefits Rider, which is attached to my certificate and the Disclosure for Group Life Accelerated Benefits Rider. However, I still wish to pursue the request.
2. I declare that this application is voluntary and that I have not been coerced by any third party.

AUTHORIZATION

I authorize the sources stated below to give to BEST Life and Health Insurance Co. information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any employer. I understand that this information will be used by BEST Life and Health Insurance Co. to determine eligibility for the payment of an accelerated death benefit. Name and Address of Physicians, Hospitals or Clinics Consulted are named below (please provide).

Signature of Insured (must be signed within 30 days of the date signed by the authorized representative of BEST Life) Date Signature of Owner, if other than the Insured Date
Signature of Insured's Guardian, if Insured is a minor or incompetent Date Signature of Irrevocable Beneficiary, if applicable Date
Signature of authorized representative of BEST Life and Health Insurance Company. Date

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