
Administered By:
Vision Financial Corporation
17 Church Street, P.O. Box 506
Keene, NH 03431-0506
Telephone: (855) 241-9891 Option 2

## REQUEST FOR PAYMENT OF ACCELERATED BENEFIT

1. INSURED'S Name _____ Date of Birth _____
2. OWNER'S Name _____ Social Security No. _____
3. OWNER'S Address _____ _____ _____ _____
   *Street* *City* *State* *Zip*
4. Amount of Benefit Requested: (Any benefit payment made will be in a lump sum unless otherwise requested.)

| POLICY NUMBER | AMOUNT REQUESTED |
|---|---|
| | |
| | |
| | |
| TOTAL | |

5. What is the diagnosis of the Insured's medical condition? _____
6. When was the medical condition first diagnosed? _____
7. Is the Insured totally disabled? ____ YES ____ NO Date first disabled?_____ Date last worked?_____
8. List all physicians who have treated the Insured for this condition.

| NAME OF PHYSICIAN | ADDRESS | DATE FIRST TREATED |
|---|---|---|
| | | |
| | | |

9. Complete if the Insured has been confined to a Nursing Home for all of the preceding six months.

| NAME OF NURSING HOME | ADDRESS | DATE FIRST CONFINED |
|---|---|---|
| | | |
| | | |

### FAIR CREDIT REPORTING ACT – PRE-NOTIFICATION FORM

Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this claim which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request, a complete and accurate disclosure of the "nature and scope" of the report, if one is made, will be provided.

### AUTHORIZATION

I hereby certify that these answers are true and correct to the best of my knowledge. I understand that the completion of this form will not be construed as an admission by the Company of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract. I agree that any physician's statements, affidavits, or additional papers required by the Company will be made a part of this claim.

I authorize any medical professional, medical care institution, insurance institution, consumer reporting agency or similar institution, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or other organization having records or knowledge of me or any member of my family, to release to Combined Insurance Company, or its reinsurers, any and all such information it may require in the investigation of this claim. I certify that I have received notification regarding the Fair Credit Reporting Act, and understand that I may request a personal interview by a consumer reporting agency. I hereby waive all right of confidentiality under state and federal credit privacy laws and release from liability the user as well as the person or firm providing such information. A photocopy of this authorization will be considered as effective and valid as the original.

_____ _____ _____ _____
Insured's Signature Date Owner's Signature Date

**Irrevocable Beneficiary/Assignee:** I consent to the payment of the Accelerated Benefit and I understand that the payment of an Accelerated Benefit will reduce the Death Benefit and any available cash value or loan value of the policy.

_____ _____ _____ _____
Irrevocable Beneficiary/Assignee's Signature Date Witness Date

## REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

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

Claimant's signature Date

**FOR RESIDENTS OF 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.

Claimant's signature Date

**FOR RESIDENTS OF CALIFORNIA:** For your protection California law requires the following to appear on this form. 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.

Claimant's signature Date

**FOR RESIDENTS OF 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 the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Claimant's signature Date

**FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA:** 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.

Claimant's signature Date

**FOR RESIDENTS OF 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.

Claimant's signature Date

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

Claimant's signature Date

**FOR RESIDENTS OF 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.

Claimant's signature Date

**FOR RESIDENTS OF MARYLAND:** Any person who knowingly and willfully 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.

Claimant's signature Date

**FOR RESIDENTS OF MINNESOTA:** A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

**FOR RESIDENTS OF 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 by RSA 638:20.

Claimant's signature Date

**FOR RESIDENTS OF NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

**FOR RESIDENTS OF OKLAHOMA:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Claimant's signature Date

**FOR RESIDENTS OF 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 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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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.

Claimant's signature Date

**FOR RESIDENTS OF VIRGINIA, TENNESSEE, MAINE, or DISTRICT OF COLUMBIA:** 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.

Claimant's signature Date

**FOR RESIDENTS OF ALL OTHER STATES:** Any person who knowingly, and with intent to injure, defraud or deceive 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.

Claimant's signature Date


Administered By:
Vision Financial Corporation
17 Church Street, P.O. Box 506
Keene, NH 03431-0506
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# ATTENDING PHYSICIAN'S STATEMENT FOR ACCELERATED BENEFIT

Patient's Name:_____

Patient's Social Security No:_____

Patient's Date of Birth:_____

We have received a request for the advancement of a portion of the life insurance benefit on your patient. This is a benefit provided by Combined Ins Company 's Accelerated Death Benefit Option. The attached authorization has been given by your patient for the release of their medical records. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. What is the diagnosis of the patient's medical condition?_____
2. What date did you first treat the patient for this medical condition?_____
3. Is the patient's medical condition the result of an attempt to commit suicide? ____Yes ____No
4. Is the patient disabled? ____Yes ____No (If 'Yes', complete sections A and B)

   A. Date of Disability_____ B. Degree of Disability: ____Partial ____Total
5. What is the patient's expected life span?_____
6. Is the patient presently confined to a Nursing Home? __Yes __No

   If 'Yes', please complete the following information

   A. NAME OF NURSING HOME DATE FIRST CONFINED

   _____ _____

   B. Has the patient been confined to the Nursing Home for all of the preceding six months? ____Yes ____No

   C. Do you expect the patient to remain in a Nursing Home for the remainder of their life? ____Yes ____No

_____ _____ _____

Signature of Physician Date Social Security/IRS Number

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claim or Policy Number:
Name:
Address:

Birthdate:

This will authorize VISION FINANCIAL CORPORATION, TPA for COMBINED INSURANCE COMPANY OF AMERICA, PO BOX 506, Keene, NH, 03431-0506 to obtain necessary medical information for the purpose of evaluating the above decedent's insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to the decedent's loss or condition being evaluated.

The information to be disclosed may include but is not limited to:

| | | |
|---|---|---|
| History of Present Illness | Consultant's Report | Discharge Summary |
| Operative Reports | Pathology Reports | Laboratory Results |
| Daily Doctor's Notes | Past Medical History | Previous Admissions |
| X-Ray Reports | Other-Specify: | |

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will automatically expire (6) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Insurance Company of America. I understand that revocation will not apply to the decedent's insurance company when the law provides the insurer with the right to contest a claim under the decedent's policy or evaluate the insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

_____ Date:_____
(Signature of Responsible Party) (Must be filled in)

_____
(Relationship to Insured)

A photocopy of this authorization may be treated in the same manner as an original.