❑ American-Amicable Life Insurance Company of Texas
❑ IA American Life Insurance Company
❑ Occidental Life Insurance Company of North Carolina
❑ Pioneer American Insurance Company
❑ Pioneer Security Life Insurance Company

P.O. Box 2549 • Waco, TX 76702-2549 • 800-736-7311 • Email: claims@aatx.com

POLICY NO. _____

PART ONE: CHRONIC ILLNESS ACCELERATED DEATH BENEFIT CLAIM FORM

SECTION 1: INSURED INFORMATION (To be completed by the Insured/Policy Owner)
Please note: Failure to complete this form IN FULL may delay payment of your claim. PLEASE PRINT.

Insured's Name: _____ Insured's Date of Birth: _____

Policy Owner/Certificate Holder: _____

Policy Owner/Certificate Holder's Mailing Address: _____

_____

Enter your taxpayer identification number or SSN: _____ Percentage Requested: _____%

CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding either because 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 the IRS has notified me that I am no longer subject to backup withholding.

Policy Owner/Certificate Holder's Signature: _____

SECTION 2: CHRONIC ILLNESS HISTORY

What are the diagnoses and symptoms that prevent the Insured from caring for himself or herself and which support eligibility for a chronic illness claim?

_____

_____

Has the Insured been confined to any type of facility (e.g., hospital, nursing home, rehabilitation center) for this condition? ..... ❑ Yes ❑ No

If "Yes": list name, address and phone number of each facility and dates of confinement below.

Confinement Dates	Facility Name	Address (Street, City, State, Zip)	Phone Number

List below any physicians that have treated the Insured for this chronic condition within the past 5 years.

Treatment Dates	Physician Name	Address (Street, City, State, Zip)	Phone Number

SECTION 3. COGNITIVE IMPAIRMENT

When did you or the Insured's physician first conclude that the Insured, due to a severe cognitive impairment, requires substantial supervision to protect himself or herself from threats to health or safety?

Date of Onset:_____

List the name, relationship, and phone number of the individual (including family members), agency, and/or facility that currently provides this supervision.

Agency/Individual Name	Phone Number	Relationship	Date Supervision First Provided	Description of Assistance Provided and Frequency

(If additional space is needed for sections 2 or 3 please attached separate pages.)

SECTION 4. ACTIVITIES OF DAILY LIVING (ADL)

List the activities of daily living that the Insured needs assistance with below.

a. **Eating** – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously..... ❑ Yes ❑ No

b. **Toileting** – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.. ❑ Yes ❑ No

c. **Transferring** – moving into and out of a bed, chair, or wheelchair. ..... ❑ Yes ❑ No

d. **Bathing** – washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower ..... ❑ Yes ❑ No

e. **Dressing** – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs..... ❑ Yes ❑ No

f. **Continence** – the ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag. ..... ❑ Yes ❑ No

If "Yes" to any items above, provide the approximate date, for each ADL, the Insured was first unable to perform that particular ADL. (Month and Year) _____

CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical, professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, government agency including, but not limited to, the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company, its officers, employees, agents, or legal representative, and any insurance support organization and consumer reporting agency acting on the Company's behalf, with any and all medical records and personal information requested about me or my minor children.

I UNDERSTAND THAT THIS Authorization will be used to obtain information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use of drugs or use of alcohol.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company or its agents, to determine eligibility for benefits under an existing policy.

I KNOW that I or my legal representative may request to receive a copy of this Authorization.

I UNDERSTAND that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization at any time by requesting such in writing to the Company at the address shown above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date: _____ Legal relationship to applicant: _____

Signature of Patient/guardian/personal representative_____

PART TWO: ATTENDING PHYSICIAN REPORT
CHRONIC ILLNESS ACCELERATED DEATH BENEFIT

SECTION 1: INSURED INFORMATION (To be completed by the Attending Physician)

Insured's Name: _____ Age: _____ Insured's Date of Birth: _____

SECTION 2. DIAGNOSIS AND PRESENT CONDITION OF CHRONIC ILLNESS:

Insured's Primary Diagnosis: _____

Insured's Secondary Diagnosis: _____

When did the current symptoms first appear or accident happen? (mm/dd/yyyy) _____

When where you first consulted? _____

Has the Insured ever had a similar condition? ("Yes", state when & describe)..... ❑ Yes ❑ No

_____

SECTION 3. ACTIVITIES OF DAILY LIVING (ADL):

Has the Insured had a loss of functional capacity and been unable to perform for at least 90 consecutive days two or more of the following ADLs without substantial assistance? ..... ❑ Yes ❑ No

If "Yes", is the condition expected to be permanent?..... ❑ Yes ❑ No

If the Insured is unable to perform two or more ADLs without substantial assistance from another person, provide the approximate date the Insured was first unable to perform the particular ADL below:

Activity of Daily Living	Assistance Required?	Date Assistance First Required
BATHING (washing oneself)		
a. By sponge bath	❑ Yes ❑ No	
b. In the tub or shower	❑ Yes ❑ No	
c. Getting in and out of the tub or shower	❑ Yes ❑ No	
DRESSING (putting on, taking off, fastening, unfastening)		
a. Clothing	❑ Yes ❑ No	
b. Medically necessary braces, fasteners, or artificial limbs	❑ Yes ❑ No	
EATING (feeding oneself by getting food into the body)		
a. Through the mouth	❑ Yes ❑ No	
b. By feeding tube or intravenously	❑ Yes ❑ No	
TOILETING		
a. Getting to and from the toilet	❑ Yes ❑ No	
b. Getting on and off the toilet	❑ Yes ❑ No	
c. Performing associated personal hygiene	❑ Yes ❑ No	
TRANSFERRING		
a. Moving into or out of a bed	❑ Yes ❑ No	
b. Moving into or out of a chair	❑ Yes ❑ No	
c. Moving into or out of a wheelchair	❑ Yes ❑ No	
CONTINENCE	❑ Yes ❑ No	
a. Is the Insured unable to control bladder function	❑ Yes ❑ No	
b. Is the Insured unable to control bowel function	❑ Yes ❑ No	
c. Does the Insured need help performing associated personal hygiene	❑ Yes ❑ No	
d. Does the Insured have a colostomy bag	❑ Yes ❑ No	
e. Does the Insured need help caring for catheter or colostomy bag	❑ Yes ❑ No	

SECTION 3. ACTIVITIES OF DAILY LIVING (ADL) (Continued):

Provide results of any physical examination finding and diagnostic studies which support the patient's ADL dependencies identified on the previous page.

_____

_____

SECTION 4. COGNITIVE ABILITY

If the patient has a significant decline in cognitive ability, address the following questions based on the following definition of severe cognitive impairment and established using clinical evidence and standard tests. Severe cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places or time, and (iii) deductive or abstract reasoning.

Describe the patient's level of cognitive impairment based on clinical assessment and standardized screening tools.

_____

Standardized Screening Tool _____ Evaluation Date _____

Standardized Screening Tool _____ Evaluation Date _____

Does the patient require substantial supervision in order to protect himself/herself from threats to health and safety due to severe cognitive impairment? ..... ❑ Yes ❑ No

Is this condition expected to be permanent? ..... ❑ Yes ❑ No

SECTION 5. ADDITIONAL INFORMATION

Has the patient's driver's license been revoked? ..... ❑ Yes ❑ No

If "Yes", provide approximate date of revocation _____

Has the Insured been confined to any type of facility (e.g., hospital, nursing home, rehabilitation center) for this condition? ..... ❑ Yes ❑ No

Provide explanation.

_____

_____

SECTION 6. ADDITIONAL REMARKS

_____

_____

_____

PHYSICIAN INFORMATION AND SIGNATURE

Attending Physician Name (Please Print): _____ Degree: _____

SSN/TIN: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Attending Physician Signature: _____ Date: _____

IMPORTANT NOTICE

In some states we are required to advise you of the following: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska – Any 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 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.

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.

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.

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.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any 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.

Kentucky – 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 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 – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties my include imprisonment, fines, or a denial of insurance benefits.

Maryland – "Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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 state prison.

Minnesota – A person 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 or punishment for insurance fraud, as provided in RSA 638:20.

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.

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.

New York - GENERAL: 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.

Ohio – Any person who, with intent to defraud or knowing 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 – **WARNING:** 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.

Oregon – Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, 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.

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.

Utah – Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
Utah Workers Compensation claims only

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.

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.

West Virginia – 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.

In All Other States – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing a false or deceptive statement may be guilty of insurance fraud.