



Notice of Claim/Accelerated Benefit Living Benefit

GE Financial
Employer Services Group

GE Group Life Assurance Company
PO Box 810, Greenfield, MA 01302-0810

Attention: Group Life Benefits

Must Be Completed In Full

Employer's Statement

Name of Claimant (Last, First, M.I.) - PLEASE PRINT		Claimant's Aliases	Basic Annual Earnings at Time of Disability \$	Date of Last Salary Change / /
Group Account Number	Effective Date of Full-Time Employment	Effective Date of Employee's Insurance / /	Occupation	
Amount of Employee's Insurance Basic Life \$	Supplemental/Voluntary	Date Last Worked / /	Has employee returned to work? (If "Yes," give date) <input type="checkbox"/> Yes <input type="checkbox"/> No	Have premiums ceased? (If "Yes," give Date) <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Leaving Work <input type="checkbox"/> Retired <input type="checkbox"/> Absent on Sick Leave <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Absent Because of Temporary Layoff <input type="checkbox"/> No Longer Employed				

Important Notice: If on file in your office, please provide us with a copy of the Employee's Enrollment Card, along with any subsequent change of beneficiary or benefit election forms.

Name of Employer	Telephone Number	
Address (No., Street, City, State, ZIP Code)	Fax Number	
Signature (Authorized Personnel)	Please Print or Type Name and Title of Authorized Personnel	Date Signed

Employee's Statement

Date of Birth	Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Last Worked	Telephone Number
Address (No., Street, City, State, ZIP Code)				

Please check only one: <input type="checkbox"/> I elect to receive the accelerated benefit on my Basic Life only. <input type="checkbox"/> I elect to receive the accelerated benefit on my Supplemental/Voluntary Life only. <input type="checkbox"/> I elect to receive the accelerated benefit on both my Basic and my Supplemental or Voluntary Life.	Is this policy subject to any provisions of a divorce decree? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there an irrevocable beneficiary on this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, the consent of the irrevocable beneficiary must be obtained agreeing to the payment of the advance benefit in a form which is satisfactory to us.
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Describe the condition which is the basis for applying for benefits under the accelerated benefit option.

Names and addresses of all attending physicians/hospitals who treated you for this illness.	Date you first consulted a physician for this condition.
If you feel additional information would be helpful, please submit it on a separate piece of paper.	

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, the Medical Information Bureau or similar organization, insurance or reinsurance company, to disclose or furnish to **GE Group Life Assurance Company (GEGGLAC)** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. I further authorize any employer, group policyholder or benefits plan administrator to disclose or furnish my employment, financial and wage information to GEGGLAC and its legal representatives.

I authorize GEGGLAC to use or disclose this protected health information to any reinsurer and to any person or entity performing a business or legal function on behalf of GEGGLAC or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect a claim; (3) I have the right to revoke this authorization at any time by writing to GEGGLAC at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date Signed
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WARNING

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT: 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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN FLORIDA: "Any person who knowingly and with intent to defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

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

IN NEW YORK: "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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

Attending Physician's Statement

Application for Accelerated Benefit Option (Living Benefit)

Group Account Number	Insured's Name	Date of Birth
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TO THE PHYSICIAN: The insured is requesting an advance payment of life insurance proceeds due to terminal illness. Your statements are needed to determine eligibility for this advance payment.

History

When did symptoms first appear or accident happen?	Date of Initial Diagnosis	Date of Last Visit
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Diagnosis

List diagnoses including complications, if any. _____

Please give current patient status including any objective findings which can include: current X-rays, EKGs and laboratory data (if available, please provide copy of your clinical notes.) PLEASE NOTE: Additional information can be submitted at your discretion.

Is this condition terminal? Yes No How long do you expect patient to live? _____

Has patient lost the ability to perform two or more Activities of Daily Living? Yes No

On what date did patient become unable to perform two or more of the Activities of Daily Living? _____

Please check off all Activities of Daily Living that patient is unable to perform without substantial assistance from another person:

- bathing eating dressing
- toileting transferring continence

Comments: _____

Treatment

Nature of treatment, including surgery and medications prescribed. _____

Progress

Since the initial diagnosis, the patient's condition is: improved unchanged worse
Patient is: ambulatory house confined bed confined nursing home/hospital confined

Date of hospitalization: _____

Name and address of hospital/nursing facility _____

Competency

Is the patient competent to endorse checks and direct the use of proceeds? Yes No
To the best of your knowledge, has a guardian or conservator been appointed? Yes No Unknown

Physician's Verification

Name of Attending Physician (Please Print) _____
Address _____ Phone Number _____

Attending Physician's Signature _____ Date Signed _____