Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Statement of Claim for Living Benefits

To Be Completed by Insured

Answer all questions that apply.

The Insured or guardian is responsible for completion of this proof without expense to the company.
The company in furnishing this form does so without admitting any liability or waiving any of its rights under the policy on which this claim is made.

Insured's full name

Insured's Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legal Separation

❑ Male ❑ Female

Date of birth

Cert. or Soc. Sec. Number

Home address (Number and Street) (City) (State) (ZIP Code) Telephone Number

Employed by

Occupation

Date employed

Name of Group

Group Master Policy Number

Describe injury or sickness

Give the date you were first diagnosed for this injury or sickness

On what date were you first treated by a physician?

Name below all physicians who have treated you since that date.

Name	Address	Dates of treatment From	To

Are you insured under any other policies issued by this company? ❑ Yes ❑ No If "Yes," give policy numbers.

I hereby request any living benefit payable to me under the terms of my group life insurance coverage. I understand that any living benefit is payable only while I am alive and that this benefit may be taxed to me when received. In a community property state, my spouse must consent to the payment of this benefit. The consent of my beneficiary is required. I understand that the benefit paid to my beneficiary will be reduced by the amount of living benefit paid to me. I have read and understand the Disclosure Statement for Accelerated Benefits.

Insured's Signature______________________________ Date ______________________

Beneficiary's Signature ______________________________ Date ______________________

Address ____

(Witnesses) ______________________________ Date ______________________

List of community property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington State.

Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of United of Omaha Life Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to: ATTN: Group Life Claims, United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below):____

____

______________________ Printed Name of Insured Person

______________________ Printed Name of Authorized Person

______________________ Signature of Authorized Person

______________________ Relationship to Insured

______________________ Date

Notice

GENERAL — FEDERAL TAX LAWS IMPOSE WITHHOLDING REQUIREMENTS WITH RESPECT TO LIFE INSURANCE POLICIES. IF YOU ELECT TO HAVE FEDERAL INCOME TAX WITHHELD FROM PAYMENT, SOME STATES WILL REQUIRE THAT STATE INCOME TAX ALSO BE WITHHELD.

YOU MUST FURNISH YOUR SOCIAL SECURITY NUMBER WHETHER OR NOT YOU ELECT NO WITHHOLDING.

CAUTION — IF YOU ELECT NOT TO HAVE WITHHOLDING APPLY, OR IF YOU DO NOT HAVE ENOUGH FEDERAL INCOME TAX WITHHELD, YOU MAY BE RESPONSIBLE FOR PAYMENT OF ESTIMATED TAX. YOU MAY INCUR PENALTIES UNDER THE ESTIMATED TAX RULES IF YOUR WITHHOLDING AND ESTIMATED TAX PAYMENTS ARE NOT SUFFICIENT FOR THE TAX YEAR.

Required Disclosure Statement For Accelerated Benefits
United of Omaha Life Insurance Company

Living Benefits Are Not Payable If The Master Policy Ends

(Washington — only) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. **If you receive a payment of accelerated benefit from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI) and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.**

(Generic — all other states) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. You may receive ______ % of the face amount of your life insurance benefit up to a maximum of $ ____________ .

Your Life Insurance Death Benefit Will Be Reduced By The Amount Of Accelerated Benefit That Is Paid. Unlike Conventional Life Insurance Benefits, Accelerated Benefits May Be Taxable. You Or Your Designated Beneficiary Should Consult A Personal Tax Advisor.

Accelerated Death Benefit Application Instruction

To apply for an Accelerated Death Benefit, please follow the steps noted below:

Step 1. Attending physicians' Statement of Condition must be filled out in its entirety.

Step 2. You must contact the beneficiary you have noted and inform him/her of your accelerated death benefit request and the amount you have requested.

Step 3. Your beneficiary must complete the Consenting Beneficiary Form and return it to you in order for you to file the claim.

Step 4. Submit both the Physicians' Statement of Condition along with the Consenting Beneficiary Form and return to:

United of Omaha Life Insurance Company
Attention: Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175

Consent Beneficiary Form

I have read and understood that ____ will receive
Name of Insured

the sum of $ ___________ , as an Accelerated Death Benefit. I further understand that as the beneficiary, the remaining life insurance benefit will be reduced by _____ %.

Beneficiary Signature Date

Address

To Be Completed By Master Policyholder or Group Administrator

Name of Insured

Date of birth	Cert. or Soc. Sec. Number	Eff. date of certificate

Date of employment	Date last at work	Last occupation	Annual salary

Why did he or she cease work on date given above?

Date insurance terminated	If not terminated, give "paid to" date.

Master Policy Number	Insurance class	Amount of life insurance at time of last day of work

Name of beneficiary shown on your records	Address	Relationship to Insured

We hereby certify that, to the best of our knowledge and belief, the above statements are correct.

Name of Group	Branch or division	
Address of Group	Authorized representative's signature	Date

Attending Physician's Statement of Terminal Condition

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

1. PATIENT'S NAME____ AGE __________

2. HISTORY
   - (a) When did symptoms first appear or accident happen? — (a) Mo. ______________ Day ______________ , __________
   - (b) Has patient ever had same or similar condition? If "Yes," state when and describe. — (b) ❑ Yes ❑ No ________________________________

3. PRESENT CONDITION
   - (a) Subjective symptoms — (a) ________________________________
   - (b) Objective findings (Includes results of current X-rays, EKGs or any other special tests.) — (b) ________________________________
   - (c) Is patient (Check one) .... — (c) ❑ ambulatory? ❑ bed confined? ❑ house confined? ❑ hospital confined?

4. DIAGNOSIS

5. TREATMENT
   - (a) Date of first visit .... — (a) Mo. ______________ Day ______________ , __________
   - (b) Date of last visit.. — (b) Mo. ______________ Day ______________ , __________
   - (c) Frequency of visits.. — (c) ❑ Weekly ❑ Monthly ❑ Other ______________________
   - (d) When did you last examine the patient?.............................. — (d) Mo. ______________ Day ______________ , __________

6. TERMINAL CONDITION
   - (a) Current treatment
   - (b) Prognosis: Is this injury or sickness terminal (expected to result in death from which there is no reasonable prospect of recovery)? If Yes, please give expectations for continued survival: _____ 6, _____ 12, or _____ 24 months. If "No," please give expectations for continued survival, __________ months.
   - (c) Has patient been seen/examined by any consultant? If so, please attach any pertinent reports (tissue pathology, radiology, oncology, etc.) and name/address of same.

7. MENTAL CONDITION
   Is the patient competent to endorse checks and direct the use of the proceeds thereof? — ❑ Yes ❑ No

8. REMARKS

Attending Physician:

After you have fully completed this form, attach copies of the following materials:
- **Office notes for the period of treatment to the present**
- **Test results showing objective findings**
- **Hospital discharge summaries**
- **Consulting physician reports**

Date	Type or Print Physician's Name	Tax I.D. or Social Security Number

Signature (Attending Physician)	Degree	Telephone

Street Address	City or Town	State or Province	ZIP Code

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: 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.

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.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she 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.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

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.

Kansas: 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 as determined by a court of law.

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.

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

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 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.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed 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.

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

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: 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 penalties.

Virginia: Any person who, with the 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 may have violated state law.