Amalgamated Life Insurance Company
Policy Services Department
333 Westchester Avenue
White Plains, NY 10604
1-914-367-5000

ACCELERATED BENEFIT CLAIM FORM

Please Type or Print

EMPLOYER/GROUP NAME			POLICY NO.
EMPLOYEE/INSURED'S Name & Address	(Last)	(First)	(Middle Initial)
Street			
City, State, Zip			
Social Security #		Date of Birth	
Telephone #			Date Condition Was First Identified
Place of Birth (City, State)			Sex
Occupation		Life Insurance Amount	Employment Date

CERTIFICATION

I Certify that the information I have provided on this form is true, complete and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

Signature of Employer/Policyholder Title Date

Signature of Insured Date

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Physician Completes	**ATTENDING PHYSICIAN'S STATEMENT**	
Name of Patient		Date of birth
When did symptoms first appear or accident happen?	Date patient ceased work because of disability?	Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
Has patient ever had same or similar condition? If "Yes," state when and describe. ☐ Yes ☐ No	Names and addresses of other treating physicians	
Diagnosis (including complications)	Subjective symptoms	
Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)		
Date of first visit	Date of last visit	Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)
Nature of treatment (including surgery and medications prescribed, if any)		
Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed	Is patient ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined ☐ Hospice care	
Has patient been hospital confined? ☐ Yes ☐ No If "Yes," give name and address of hospital If "Yes," confined from _____ through _____		
Please indicate patient's long-term and short-term prognosis (including life expectancy)	Indicate duration of illness (from initial onset to present)	

Attending Physician _____ Degree _____
Please Print

Medical Records Telephone Number _____ Medical Records Fax Number _____

Street Address _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

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Family Completes | **RELEASE OF INFORMATION**

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION
(This Authorization complies with the HIPAA Privacy Rule)

I, as the Insured or the Insured's Authorized Representative, authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about the Insured to Amalgamated Life Insurance Company, its employees, agents or representatives (Amalgamated Life Insurance Company). "Information" may include the Insured's entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning the Insured, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report or any other medical or non-medical information about the Insured.

The information to be disclosed under this Authorization may be used by Amalgamated Life Insurance Company to: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage in-force or applied for with Amalgamated Life Insurance Company.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to Amalgamated Life Insurance Company. I am aware that my revocation will not be effective until received by Amalgamated Life Insurance Company and will not be effective regarding the uses and/or disclosures of the Insured's Information that Amalgamated Life Insurance Company has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides Amalgamated Life Insurance Company with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent Amalgamated Life Insurance Company from being able to process an application for coverage, determine eligibility or make benefit payments. The Insured's physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

Name of Insured _____ Insured's Date of Birth _____

Signature of Insured or Insured's Authorized Representative* _____

Date Signed _____

* Authorized Representative's Authority or Relationship to Insured (attach any supporting documentation) _____

_____

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