

## 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		Sex
Place of Birth (City, State)	Occupation		Employment Date
		Life Insurance Amount	

### 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
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Signature of Insured	Date
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**Return to: Amalgamated Life Insurance Company  
Attn: Policy Services Department  
333 Westchester Avenue  
White Plains, NY 10604**

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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Has patient ever had same or similar condition? If "Yes," state when and describe. <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____	
Nature of treatment (including surgery and medications prescribed, if any) _____			
Has patient <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		Is patient <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined <input type="checkbox"/> Hospice care	
Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ <div style="text-align: center; margin-left: 150px;">Please Print</div>			
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
<p><b>AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION</b> <b>(This Authorization complies with the HIPAA Privacy Rule)</b></p>	
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
<p>Name of Insured _____ Insured's Date of Birth _____</p>	
<p>Signature of Insured or Insured's Authorized Representative* _____</p>	
<p>Date Signed _____</p>	
<p>* Authorized Representative's Authority or Relationship to Insured (attach any supporting documentation) _____</p> <p>_____</p>	

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