Application for Accelerated Death Benefit- ❑Employee ❑Spouse

Employer: Has the employee assigned their benefits to another person or entity? ❑Yes ❑ No
Note: If yes, ***STOP*** here and inform the employee that an ADB is not available.

Please complete this section and forward the package to the employee. When the employee returns the information please forward it along with the prior two years enrollment forms to: Aetna Life Insurance Company, 151 Farmington Avenue, Hartford CT 06156-3007
********You may want to review your Plan Documents before completing the Application. ********

Employer Name and Address	Control-Suffix-Account _____-_____ -_____ Amount of Basic Insurance $ _____ Amount of Optional Insurance $ _____

1. If insurance is based on earnings, basic rate of earnings on date last worked.

   $_____ per ❑ Hour ❑ Week ❑ Month ❑ Year

2. Are premiums still being paid on this employee? ❑ Yes ❑ No	3. Effective Date of Employee's Insurance

3. Date Employed	5. Date Last Worked	6. Employee Certificate Number and Social Security Number

7. Was the employee required to submit evidence of insurability? ❑ Yes ❑ No
Note: If yes, date evidence submitted:

8. What is the Disability Provision? ❑ Premium Waiver ❑ PTD ❑ DBO-AID ❑DBO
Our Premium Waiver department will contact you regarding your eligibility.

9. Has employee submitted a claim for permanent total disability? ❑Yes ❑ No
Note: If yes, date claim submitted:

10. Maximum allowable ADB
Basic $_____ and/or _____%
Optional $_____ and/or _____%

_____	_____	_____
Date	Signature of Employer's Benefit Representative	Telephone

Employee: Complete this section. Send this application together with the Insurer's Copy of the "Authorization to Release Information" form to your employer listed above. Your medical records can be sent to Aetna Life Insurance Company, 151 Farmington Avenue, Hartford CT 06156-3007.

********PLEASE PRINT OR TYPE THE INFORMATION BELOW********

Employee's Name & Address	Date of Birth	Social Security Number
Spouse's Name & Address (if applicable)	Date of Birth	Social Security Number

Amount of accelerated death benefit requested: Basic $_____ and/or _____%
Optional $_____ and/or _____%
Note: The amount you request can not exceed the amount shown in box 10.

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 claim was provided by the applicant. California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and my be subject to fines, confinement in a state prison and substantial civil penalties. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

_____	_____	_____
Date	Signature of Employee	Telephone

Request for Medical Documentation

_____
Date

Group Policy No: _____ Employer: _____

Employee Name: _____ Employee's SSN: _____

Spouse Name(if applicable): _____ Spouse's SSN: _____

Dear Doctor:

I have elected to claim part of my group life insurance benefits to which I may be entitled if my life expectancy is less than _____ months (specified under the Plan).

I must provide the following medical documentation to the Insurance Company for evaluation of benefit eligibility:

- A narrative summary describing the diagnosis, prognosis, modality of treatment, and clinical response to treatment,
- Clinical records for the terminal disease.
- An assessment of mental competency.
- Names, addresses, and phone numbers of other treating physicians, if applicable.
- Your assessment on the medical probability that my life expectancy will be (.....) months or less. Please provide the medical rationale in support of your opinion.
- If it is medically probable that my life expectancy will exceed (.....) please provide an opinion on my projected life expectancy. If you are unable to establish a projected life expectancy at this time, please contact me if this situation changes.

Attached is a signed Release authorizing you to submit the requested information to the Insurance Company, for their review. **Please forward the records, with a copy of this letter to assure proper identification, directly to the Insurance Company. Their address is Aetna Life Insurance Company, 151 Farmington Ave, Hartford CT 06156-3007.**

Thank you for your prompt assistance in this matter.

_____ _____
Signature of employee Date

_____ _____
Signature of spouse (if applicable) Date

Instructions: Sign and date this Request for Medical Documentation. Send this request and the Physician's copy of the Authorization to Release Medical Information form to your physician.