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## Accelerated Benefit Claim Statement— Insured/Spouse

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- ☞ If you live in the state of Arizona, the following statement applies to you:**  
For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- ☞ If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**  
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ☞ If you live in the state of California, the following statement applies to you:**  
For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ☞ If you live in the state of Colorado, the following statement applies to you:**  
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.
- ☞ If you live in the District of Columbia, the following statement applies to you:**  
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.
- ☞ If you live in the state of Florida, the following statement applies to you:**  
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ☞ If you live in the state of New Jersey, the following statement applies to you:**  
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- ☞ If you live in the state of Oregon, the following statement applies to you:**  
Any person who, with 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 be guilty of insurance fraud.
- ☞ If you live in a state other than mentioned above, the following statement applies to you:**  
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.

***To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.***

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms “we,” “us,” “our,” and the like, refer to each as applicable.



**IMPORTANT NOTICE:**

RECEIPT OF AN ACCELERATED BENEFIT WILL REDUCE YOUR DEATH BENEFIT. ALSO, IT MAY AFFECT YOUR ELIGIBILITY FOR A STATE OR FEDERAL PROGRAM, SUCH AS MEDICAID, AND BENEFITS MAY BE TAXABLE. YOUR TAX ADVISOR SHOULD BE CONSULTED.

**Part I To be completed by Insured (and Spouse, if applying for Dependent Accelerated Benefit) along with the Form W-9 Notice (on reverse side)**

1. Full name of insured ( <i>Please print.</i> )	2. Social Security number	3. Date of birth
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4. Legal residence (*street, city or town, state, zip code*) \_\_\_\_\_

5. Full name of Spouse ( <i>if applying for Dependent Accelerated Benefit</i> )	6. Social Security number	7. Date of birth
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8A. Percentage of amount of life insurance elected _____ % ( <i>Subject to the Accelerated Benefit limits set forth in your certificate of insurance.</i> )	8B. Elected amount of Accelerated Benefit \$ _____
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9. Date illness began	10. Date first consulted physician	11. Describe nature of illness
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12. Have you had the same or similar illness before?     Yes     No    If "Yes," please provide dates and details.

13. Name of primary physician(s)	Full address(es)	Date of first and last treatment

Name of hospital(s)	Full address(es)	Date(s) of Confinement

14. I AUTHORIZE any physician, medical practitioner, hospital, pharmacy, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Union Security Insurance Company, its legal representative or agency employed by the Company, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Union Security Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Union Security Insurance Company EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

I certify to the correctness of these statements. Insured's signature \_\_\_\_\_ DATE

Spouse's signature \_\_\_\_\_ DATE

by \_\_\_\_\_  
IF INSURED OR SPOUSE CANNOT SIGN RELATIONSHIP

(If Power of Attorney, Guardian or Conservator, please forward a certified copy of the court order evidencing your appointment.)

15. **Disclaimer Statement:** I understand that receipt of an Accelerated Benefit may affect my eligibility for a state or federal program, such as Medicaid, and that these benefits may be taxable. Also, I understand that the death benefit will be reduced if I receive an Accelerated Benefit.

INSURED

\*BENEFICIARY

SPOUSE

\*Note: If you have designated an irrevocable beneficiary or if you are requesting an Accelerated Benefit in excess of 50% of your amount of life insurance, your beneficiary's signature is required before an Accelerated Benefit can be paid to you.

**PAYMENT OF BENEFITS**

If the amount of the life insurance you accelerated plus interest exceeds the required minimum, a ProviderFund account will automatically be opened in your name. ProviderFund account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money.

If you are a resident of MS or PA, Assurant Employee Benefits also offers optional payment methods. For a complete discussion of the options available in your state, call your claims representative at **800.451.4531**.

**IMPORTANT FORM W-9 NOTICE**

Under Federal law every financial institution that pays you interest is required to have you certify 1) your Social Security number (or other taxpayer identification number) and 2) whether or not the Internal Revenue Service has notified you that you are subject to Backup Withholding Order on interest and dividends. **It is very important to you** that we have your **Social Security number** (or other taxpayer identification number) and **Backup Withholding status** certification.

Although everyone must file a certification like the form below (if you do not, the IRS can subject you to a \$50 penalty), you are not subject to a Backup Withholding Order unless you have been so notified by the IRS. If you do not file a certification, the IRS automatically requires all financial institutions to withhold at least 31% of all interest and dividends they credit to your account, and send the money to the IRS as a prepayment of your possible tax liability.

Please **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number (or other taxpayer identification number), it is easy to apply for one at a local Social Security office.

**Life Benefit Center  
Substitute Form W-9**

**Certification Form of  
Taxpayer Identification Number**

Please list your Social Security number \_\_\_\_\_ (or other taxpayer identification number).

I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends. (If you have been notified, please cross out the portion of the sentence beginning with "2").

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Insured's signature \_\_\_\_\_ Date \_\_\_\_\_

Please print your name \_\_\_\_\_

**Part II To be completed by employer**

1. Full name of insured (Please print.)	2. Certificate number	3. Effective date of insurance: A. on insured B. on dependent	4. Date employed
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5. Full-time: <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time: <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Usual number of hours worked per week	7. Date insured ceased working usual number of hours per week	8. Reason insured ceased working
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9. Occupation, position or title	10. Basic salary rate as of the policy determination date immediately preceding the date last worked (Please refer to your Group Policy Schedule.) \$ _____ per
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11. Legal residence (street, city, town, state)	12. Employer's name and full address
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13A. Full amount of Term Insurance Full amount of Dep. Life Insurance	13B. Date of last increase in the amount of life insurance	14. Accelerated Benefit amount
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15A. Due date of last premium paid by or on behalf of insured	15B. Mode of Premium Payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually
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16. Group policy no. _____ Group participation no. _____ Account no. _____	Name of group policyholder _____ Telephone number _____ Name of administrator _____ (if other than policyholder) Note: Third Party Administrators must also complete a TPA Form KC3508. Telephone number _____
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**Please forward the original application/beneficiary changes (if maintained by the policyholder).**

17. Have you any additional information relating to this claim? \_\_\_\_\_

18. We hereby certify that the above facts are true to the best of our knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
AUTHORIZED SIGNATURE OF THE POLICYHOLDER WITH NO FINANCIAL INTEREST IN THE CLAIM

After you have had your Attending Physician complete the Accelerated Benefit Claim Statement—Supplement, Form KC3510, please return to: **Assurant Employee Benefits**, PO Box 419876, Kansas City, Missouri 64141-6876.