OXFORD®
LIFE INSURANCE COMPANY

2721 North Central Avenue, Phoenix, Arizona 85004-1172
(866) 641-9999

ACCELERATED DEATH BENEFIT ELIGIBILITY FORM

UPON COMPLETION RETURN TO ADDRESS INDICATED ABOVE

PART A – To be Completed by Owner of the Policy Under Which the Claim is Being Filed	
POLICY NUMBER	OTHER POLICY NUMBERS UNDER WHICH A CLAIM IS BEING FILED
OWNER'S NAME	OWNER'S TELEPHONE NUMBER
OWNER'S ADDRESS	
OWNER'S SOCIAL SECURITY NUMBER	

❑ I want to make a claim for the maximum accelerated death benefit available to me under the above-referenced policy(ies).

❑ I want to make a claim for a part of the accelerated death benefit available to me under the above-referenced policy(ies) in the amount of $_____.

Note: If the amount indicated above exceeds the maximum accelerated death benefit, the claim amount will default to the maximum accelerated death benefit available.

Disclosures

- Your accelerated death benefits are governed solely by the terms of your policy.
- Any outstanding policy loans will affect the amount of accelerated benefits; please contact our Policyholder Services department for details regarding your specific situation.
- Accelerated benefit payments from this policy may qualify for special tax status, if, according to federal definitions, the insured qualifies as terminally ill, or qualifies as chronically ill and uses the accelerated benefit to pay for costs incurred by the insured for qualified services provided to the insured during the chronic illness. However, if the accelerated benefit is based on a medical condition not defined as a terminal or chronic illness under the federal tax code, the benefits may be taxable. If so, you may incur a tax obligation. Neither Oxford Life Insurance Company nor any agent representing it is authorized to give legal or tax advice. Please consult a qualified legal or tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.
- Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or that of your spouse or dependents.
- Receipt of these accelerated death benefits may adversely affect your eligibility for future increases in life insurance coverage.
- If accelerated death benefits are paid, continue premium payments must be made, unless waived under the provisions of the policy, to keep life insurance coverage in force.

Certification

Under penalty of perjury, I certify that: (1) the number shown on this form is my correct Social Security/Taxpayer Identification number; and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and (3) I am a U.S. citizen or other U.S. person. NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

NOTE: If you are not a U.S. citizen or other U.S. person, please contact us for an explanation of your tax treatment, and you must cross out item 3 above.

_____ _____

Owner's Signature **Date**

_____ _____

Spouse's Signature **Date**

(Required if you reside in a community property state: AZ, CA, ID, LA, NV, NM, TX, WA or WI)

Statement of Irrevocable Beneficiary and Assignee (if any)

Each undersigned hereby releases all rights, title, interest, and claim in and to any accelerated benefit proceeds claimed as to the policy identified above. This release is in all respects absolute and no right, title, interest, or claim, vested or contingent, present or future, is reserved in the policy to the undersigned, or to anyone claiming through the undersigned (including, but not limited to, any Beneficiary designated under this policy), at this or any future time, for the benefits paid under any accelerated benefits.

Irrevocable Beneficiary or Assignee (Corporate or Individual)

Name_____ **Signature** _____

Title if Assignee _____ **Date** _____

PART B– To be Completed by the Treating Physician who Diagnosed the Illness for Which You are Filing this Claim	
DATE OF DIAGNOSIS	DIAGNOSIS CODE
DIAGNOSIS DETAILS (SUBJECTIVE, OBJECTIVE, MEDICATIONS, SURGERIES, ETC.)	

ANTICIPATED DATE OF LIFE EXPECTANCY (IF TERMINALLY ILL)
CHECK ALL ACTIVITIES OF DAILY LIVING (ADLs) THE INSURED CAN NO LONGER PERFORM WITHOUT ASSISTANCE ❑ Bathing ❑Continence ❑Dressing ❑Eating ❑Toileting ❑Transferring
THE TIME FRAME IN WHICH THE INSURED HAS BEEN UNABLE TO PERFORM THE CHECKED ADLs
PLEASE INDICATE WHETHER THE INSURED HAS SEVERE COGNITIVE IMPAIRMENT AND, IF SO, THE SEVERITY
PLEASE INDICATE WHETHER THE INSURED IS CONFINED TO A NURSING HOME FACILITY AND, IF SO, THE DATE OF ADMISSION
PLEASE INDICATE WHETHER THE INSURED IS RECEIVING HOME HEALTH CARE AND, IF SO, THE DATE SUCH SERVICES BEGAN

DOCTOR'S NAME	DOCTOR'S TELEPHONE NUMBER
DOCTOR'S SPECIALTY	DOCTOR'S DEGREE
DOCTOR'S ADDRESS	
HOSPITAL NAME	HOSPITAL PHONE NUMBER
HOSPITAL ADDRESS	

DOCTOR'S SIGNATURE	DOCTOR'S LICENSE NUMBER	DATE

PART C– To be Completed by the Insured	
INSURED'S NAME	INSURED'S DATE OF BIRTH

- When did symptoms of the condition for this claim begin?

  _____

  _____

  _____.

- When was a doctor first consulted for this condition?

  _____

  _____.

- Name, Address and Phone Number for the Doctor:

  _____

  _____.

- Was there a hospital confinement for this condition?

  _____

  _____

  _____.

  - Name, Address and Phone Number for the Hospital:

    _____

    _____.

- List the names of all doctors/hospitals where treatment was received within the past five years for any illness or condition: If additional space is needed, submit additional names on a separate sheet of paper.
  - Name: _____

    Address: _____

    Phone Number: _____

    Dates of Treatment: _____

    Nature of Treatment: _____

  - Name: _____

    Address: _____

    Phone Number: _____

    Dates of Treatment: _____

    Nature of Treatment: _____

  - Name: _____

    Address: _____

    Phone Number: _____

    Dates of Treatment: _____

    Nature of Treatment: _____

  - Name: _____

    Address: _____

    Phone Number: _____

    Dates of Treatment: _____

    Nature of Treatment: _____

AGREEMENT: The Insured Person agrees –

(1) That all of the above statements and answers are complete and true to the best of his or her knowledge and belief; and

(2) To cooperate with the Company in its investigation of this claim by providing assistance including, but not limited to, completing, signing, and submitting any questionnaire or authorization form needed by the Company, in its sole opinion, to conduct its investigation. I understand that no insurance agent of the Company is authorized to make any claim decision or any representation as to whether any claim should or will be paid. I acknowledge that, due to the requirements of certain medical providers and others as well as the requirements of applicable law, the authorization of someone other than myself may be required to acquire medical or other records necessary for the Company to consider my claim, potentially delaying the processing of such claim.

INSURED PERSON MUST COMPLETE THE ATTACHED HIPAA AUTHORIZATION

Signature of Insured Person _____ Date _____

FOR YOUR PROTECTION – THE LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM

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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California and Texas: 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.

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, denials 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly, and with intent to defraud any insurance company or other person, files a 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.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

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 Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss of benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal 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.

_____ (Claimant's Signature)

Ohio: 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, is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: 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 statement may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the 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.

IN ALL OTHER STATES: 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.

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule

_____ _____

Name(s) of Primary Proposed Insured/Patient Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB Group, Inc. (“MIB”) or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I further expressly authorize Oxford Life Insurance Company, or its reinsurers, to make a brief report of my personal and/or protected health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, **Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Insured Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

❑ Power of Attorney ❑Other (please describe):_____

Proposed Insured Policy or contract number (If known): _____