BC Life & Health Insurance Company
Life Claims Unit
1350 Main Street
Springfield, MA 01103-1630

Claim for Personal Accelerated Death Benefit

The furnishing of forms does not constitute an admission of liability on the part of the Company.

Employee Instructions

1. Answer all of Section 2, Statement of Claimant. Print all answers clearly in ballpoint pen. If you change your answer, place your initials next to the correction.

2. Have your doctor complete 0003364 Statement of Attending Physician. You can get this form from the employer. Also, include lab results and x-rays, if applicable. The x-rays will be returned to the physician.

3. If applicable, provide the following documentation:
   - If you are divorced, a copy of the court approved divorce settlement agreement.
   - If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary, for payment of a personal accelerated death benefit.

4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

Employer Instructions

1. Check that the employee has completed, dated and signed this claim form. Verify that all required documentation has been provided.

2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.

3. Complete all of Section 1, Statement of Employer.

4. Include a copy of the employee's signed application card.

5. Send this claim form and all required documentation to:
   BC Life & Health Insurance Co.
   Life Claims Unit
   1350 Main Street
   Springfield, MA 01103-1630

Section 1, Statement of Employer

POLICY NUMBER	CERTIFICATE NUMBER	BILLING UNIT NUMBER
EARNINGS (WEEKLY) $	AMOUNT OF INSURANCE	SOCIAL SECURITY NUMBER
NAME OF EMPLOYEE		SEX ❑Male ❑Female
❑Married ❑Single ❑Widowed ❑Divorced		BIRTHDATE (Mo, Day, Yr)
ADDRESS OF EMPLOYEE (Number & Street, City, State, Zip)		
DATE ENTERED FULL-TIME EMPLOYMENT	EMPLOYED IN CAPACITY OF:	
DATE LAST PHYSICALLY AT WORK FULL-TIME	REASON FOR LEAVING WORK:	
IS COVERAGE CONTINUING ON A PREMIUM PAYING BASIS? ❑Yes ❑No	IF "NO" WHAT WAS DATE OF LAST PREMIUM PAYMENT?	
NAME OF BENEFICIARY	RELATIONSHIP AGE	
POLICYHOLDER		
SIGNATURE OF EMPLOYER	EMPLOYER'S PHONE NUMBER	
TITLE	DATE	

Section 2. Statement of Claimant

All questions should be fully answered by the insured or his legally appointed guardian or committee.

NAME (First, Middle, Last)	BIRTHDAY (Mo, Day, Yr)

LEGAL ADDRESS (Number & Street, City, State, Zip)

STATE NATURE OF QUALIFYING MEDICAL CONDITION:

INDICATE DATE THAT YOU LAST PHYSICALLY WORKED (Mo, Day, Yr)	INDICATE AMOUNT OF BENEFIT NOW BEING CLAIMED:

Are you in the process or have you converted your Group Life Coverage to an Individual Policy?

Names and Addresses of Physicians who have treated you for qualifying condition	**Dates of Treatment**

BC Life & Health reserves the right to request an Independent Medical Examination at the Company's expense.

Have divorce proceedings ever been instituted by or against you? ❑Yes ❑No If so, when and where?

(If you answer yes to this question, please see #3 of Employee Instructions on the reverse side of this form.)

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ❑Yes ❑No

Enter the taxpayer identification number in the appropriate space. For most individual taxpayers, this is the Social Security Number.

Social Security No. ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Certification - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions - You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross our item (2).

SIGNATURE OF CLAIMANT	DATE	RELATIONSHIP TO INSURED

MAILING ADDRESS OF CLAIMANT (Number & Street, City, State, Zip)

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institution or person who has attended or examined me to disclose to the BC Life & Health Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

WITNESS	DATE

SIGNATURE OF EMPLOYEE

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

Home Office Use Only

POLICY NUMBER	MAIL TO ❑Payee Code _____ ❑Address Below

NAME

ADDRESS (Street, City, State, Zip)

COMPANY	SOURCE	PRODUCT
TAXPAYER I.D. NUMBER	AMOUNT OF DEPOSIT	EFFECTIVE DATE

CLAIM NUMBER	1. EXAMINED BY	2. VERIFICATION BU# Class# Plan#	3. REVIEWED BY	DATE OF: ❑Approval ❑Denial