4 EVER LIFE INSURNACE COMPANY
2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois
(888) 923-4227

ACCELERATED BENEFIT DISCLOSURE

4 Ever Life Insurance Company, the Company, is in receipt of the below-named Insured Person's written request for the Accelerated Benefit available under the group life policy issued to the insured.

The acceleration of life insurance benefits offered under the rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration of life insurance benefits excludable from income under federal law.

Receipt of acceleration of life insurance benefits may affect your, your spouse or your family's eligibility for public assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplemental social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

The Accelerated Benefit is payable to an Insured Person if the Insured Person is expected to die within 9 months.

The **Insured Person** agrees to provide the following to the Company:

1. A written request to receive the benefit. If the Insured is unable to sign a written request due to his physical condition, a written request from the primary beneficiary will be acceptable;

2. A written report signed by the licensed attending physician which certifies that the Insured, due to a medically determinable condition, has a life expectancy of 9 months or less; and

3. An acknowledgement and agreement to payment of the benefit from any assignee or irrevocable beneficiary.

The **Insured Person** understands the following:

- **THE ACCELERATED DEATH BENEFIT WILL BE AN AMOUNT EQUAL TO 50% OF THE DEATH BENEFIT APPLICABLE TO THE INSURED PERSON UNDER THE GROUP POLICY ON THE DATE OF THE PHYSICIAN'S CERTIFICATION, NOT TO EXCEED $50,000. THE BENEFIT WILL BE PAID IN ONE LUMP SUM AND IS PAYABLE ONLY ONE TIME FOR EACH INSURED.**

- **THE ACCELERTAED DEATH BENEFIT WILL REDUCE THE FULL LIFE INSURANCE BENEFIT THAT WOULD ULTIMATELY BE PAYABLE AND MAY BE TAXABLE. INSUREDS ARE ADVISED TO SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.**

- **THE AMOUNT OF THE ACCELERATED DEATH BENEFIT, PLUS THE CORRESPONDING DEATH BENEFIT, WILL NOT EXCEED THE AMOUNT THAT WOULD HAVE BEEN PAID AS THE DEATH BENEFIT IN THE ABSENCE OF THE ACCELERATED DEATH BENEFIT.**

- **THE ACCELERATED DEATH BENEFIT TERMINATES ON THE FIRST OF THE FOLLOWING:**

  1. **THE DATE COVERAGE UNDER THE POLICY TERMINATES; OR**

  2. **THE DATE OF PAYMENT OF AN ACCELERATED DEATH BENEFIT TO THE INSURED.**

- **THE INSURED PERSON UNDERSTANDS THAT THE COMPANY MAY, AT OUR OPTION, CONFIRM THE DIAGNOSIS WITH AN ADDITIONAL MEDICAL OPINION IF OUR MEDICAL DIRECTOR DOES NOT CONCUR WITH THE ATTENDING PHYSICIAN. SUCH OPINION WILL BE OBTAINED AT THE COMPANY'S EXPENSE. IF AFTER REEXAMINATION THE DIAGNOSIS STILL CONFLICT, THE REQUEST TO ACCELERATE LIFE INSURANCE BENEFITS UNDER THE POLICY WILL BE DENIED.**

ACCELERATED BENEFIT ILLUSTRATION

Death Benefit in force:	***$50,000***
Accelerated Benefit available*:	***$25,000***
Remaining Death Benefit after Accelerated Benefit has been paid:	***$25,000***

* *50 % of Death Benefit, not to exceed $50,000*

The Insured Person's signature below indicates understanding and acceptance of the terms presented on the form.

Insured

Date

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716
(800) 845-7519

IMMINENT DEATH BENEFIT
ATTENDING PHYSICIAN'S STATEMENT

Please print or type. It is important that you have answered all questions completely and accurately.

PART A. TO BE COMPLETED BY PATIENT

Name of Employee: ______________________________

Address: ______________________________

City: ____________________ State: ____________ Zip Code: __________

Phone: ( ) __________ Birthdate: ____/____/_____ Social Security Number: _____-_____-_______

Employer: ______________ Group Policy Number: ______________

PART B. TO BE COMPLETED BY PHYSICIAN

Note to Doctor: The purpose of this form is to help us determine whether your patient is eligible for imminent death, or accelerated, payment of group term life insurance proceeds. We need to evaluate the clinical condition of your patient. Please advise of any clinical findings including laboratory data and results of special test such as X-rays, CAT scan, EKG, etc. Copies of any surgical reports, hospital discharge summaries, chart notes, or narrative reports will be helpful.

Diagnosis: ______________________________

ICDA Classification: ______________________________

Course of treatment, including medications: ______________________________

____

Symptoms: ______________________________

____

When did symptoms first appear?: ______________________________

Date you recommended patient should stop working: _____/_____/_____ Why?: ______________

____

Date of first visit: _____/_____/_____

Dates of subsequent treatments: ______________________________

Prognosis: ______________________________

In your opinion, does the patient have a terminal condition? ☐Yes ☐ No

What is the terminal condition? ______________________________

In your opinion, what is the patient's life expectancy? ☐ less than 6 months

☐ 6 to 12 months ☐ greater than 12 months ☐ other:

Is the patient:

permanently hospitalized? ☐ Yes ☐ No

permanently in nursing home? ☐ Yes ☐ No

currently requiring full-time home care on a permanent basis under a physician's supervision? ☐ Yes ☐ No

If yes, explain: ____

____

Hospital or nursing home: ____

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Date Admitted: _____/____/____

Does the condition, in whole or part, result from any intentionally self-inflicted injury or suicide attempt? _____________

List other treatment or referring physicians:

Name: ______________________ City: ______________ State: ________ Zip Code: ________

Name: ______________________ City: ______________ State: ________ Zip Code: ________

Name: ______________________ City: ______________ State: ________ Zip Code: ________

Your Name: ______________________ Specialty: ______________

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Telephone Number: ________________ Taxpayer Identification Number: ______________________

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:
WARNING: Any person who knowingly:
Oklahoma: 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.
Texas: 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.

____ Date: _____/____/_____
Signature

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716
(800) 845-7519

IMMINENT DEATH BENEFIT
EMPLOYER'S CLAIM FORM

Please print or type. It is important that you have answered all questions completely and accurately.

Name of Employee: ______________________________

Address: ______________________________

City: ____________________ State: ____________________ Zip Code ___________

Birthdate: _______/________/_______ Social Security Number: ______ - ______ - _______

Date of Employment: ______/ _______/ _______ Date employee's group term life insurance effective: _____/ ______/_____

Is employee currently working? ☐ Yes ☐ No If not, date last worked: ____/ ____/ ____

Reason employee stopped working: ______________________________

Is employee now terminated? ☐ Yes ☐ No If yes, date of termination: ____/ ____/ ____

Was waiver of premium applied for? ☐ Yes ☐ No ☐ Unknown

Was conversion of this coverage applied for? ☐ Yes ☐ No ☐ Unknown

Does employee have group short-term or long term disability coverage with 4 Ever Life Insurance Company?
☐ Yes ☐ No

Policy number: ____________________ Participating Employer number (if applicable): ______________

Amount of group life insurance currently in force with 4 Ever Life Insurance Company:

Basic $_______________

Additional/Optional $_______________

Supplemental $_______________

Dependent $_______________

Spouse Coverage $_______________

Please check appropriate box and fill in the amount of salary:

- ☐ Basic Monthly Earnings Monthly rate $______________
- ☐ Basic Yearly Earnings Annual rate $______________
- ☐ Basic Contract Earnings Contract amount $______________
- ☐ Basic Weekly Earning Weekly rate $______________
- ☐ Basic Hourly Earning Hourly rate $______________
- ☐ Commissions (please attach list of commissions paid for the period specified in your 4 Ever Life Insurance Company group term life policy).

Date of last increase ____/ ____/ ____

Earnings prior to increase: $_______________ per _______________

Does employee have life insurance for dependents under your group term life policy with 4 Ever Life Insurance Company?

☐ Yes ☐ No

Job title: ____

PLEASE CONTINUE PAYMENT OF PREMIUMS UNTIL OTHERWISE NOTIFIED.

If premiums have already been terminated, give date paid through: ____/ ____/ ____

Please attach the following:

a. Original Enrollment Card and any subsequent beneficiary changes.

b. Copy of job description.

c. Copy of employment application or resume.

Prepared by: ____ Title: ______________________

Date: ____/ ____/ ____

____ Date: ______/______/______

Signature

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

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IMMINENT DEATH BENEFIT EMPLOYEE'S CLAIM FORM

Please type or print all answers. All questions are to be answered as completely and accurately as possible. If there are any unanswered questions, the review of your claim may be delayed.

Name: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip Code: ________

Phone: (_____) _______________ Birthdate: ______/ ______/______ Social Security Number: _______ - _______ - _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: ______________

Have you received a Certificate of Insurance? ☐Yes ☐ No

Name of Employer: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip Code: ______________

Date hired: ______/_______/_______ Last day at work: ______/_______/_______

Reason you stopped working: ______________________________

Job Title/Description of Duties: ______________________________

Are you self-employed at any activity? ☐ Yes ☐ No

Are you now working at your occupation or another occupation? ☐ Yes ☐ No

Are you covered under more than one group life insurance policy issued by 4 Ever Life Insurance Company?

☐ Yes ☐ No

Have you applied for a waiver of premium? ☐Yes ☐ No

Describe your present medical condition: ______________________________

____

Please provide the following information regarding any physicians who have treated you:

Physician's Name: ______________________________

Address: ______________________________

City: ______________________ State: ______________________ Zip Code: ______________

Telephone Number: (_____) ____________________

Date First Consulted: ______/______/_______ Date Last Consulted: ______/______/______

If you are under the care of more than one physician for the condition causing you to apply for this Imminent Death Benefit, please provide the same information for the other physician(s) on a separate piece of paper.

Form 1.606A - BBA (Rev. 09/2013)

Please indicate whether you are currently confined to a:

Hospital: ☐ Yes ☐ No

Nursing Home: ☐Yes ☐ No

If yes, date confinement commenced: _____/_____/_____

Is confinement permanent? ☐ Yes ☐No

Please provide name and address of Hospital or Nursing Home:

Address: ______________________________

City: ______________________ State: ______________ Zip Code: ____________

Are you currently receiving in-home care? ☐ Yes ☐No If Yes, is the care: ☐ Full-Time ☐Part-Time

Please describe the type of care and by whom provided: ______________________________

____

____

____

Is part or all of your 4 Ever Life Insurance Company group term life insurance required to be paid to your children, spouse, or former spouse as a part of a court-approved divorce decree, separate maintenance agreement, or property settlement agreement? ☐Yes ☐ No

Are you married and living in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin)? ☐ Yes ☐No

If yes, your spouse must complete the attached Consent to Payment of Imminent Death Benefit.

Have you made an assignment of all or part of your 4 Ever Life Insurance Company group term life policy?

☐Yes ☐No

If yes, the assignee must complete the attached Consent to Payment of Imminent Death Benefit. (An assignment is a transfer of your rights under the policy: it does not refer to your beneficiary designation.)

Have you made your beneficiary designation irrevocable? ☐ Yes ☐ No

If yes, the irrevocable beneficiary must complete the attached Consent to Payment of Imminent Death Benefit.

Have you filed for bankruptcy? ☐ Yes ☐No

Are you required by a government agency to use the Imminent Death Benefit to apply for, receive, or continue a government benefit or entitlement? ☐Yes ☐ No

Have you previously applied for or received an Imminent Death Benefit under 4 Ever Life Insurance Company group term life policy?

☐Yes ☐No

Have you made application to convert, or have you converted, all or part of your coverage under 4 Ever Life Insurance Company group term life coverage to an individual policy? ☐ Yes ☐No

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I certify that the above answers are true and complete and, to the best of my knowledge and belief, form the basis of my claim for an Imminent Death Benefit. I do understand that the receipt of the Imminent Death Benefit may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, my Imminent Death Benefit may be non-taxable and that these matters should be discussed with my tax advisor and/or legal advisor before applying for an Imminent Death Benefit. I further understand that this benefit provides for an accelerated benefit of life insurance, and is not intended nor designed to provide health, nursing home, or long term care benefits.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

______________________________ Date: ______/______/______

Signature

IMMINENT DEATH BENEFIT INSTRUCTIONS

Please Read the Following and Each of the Attached Forms Carefully

- The Imminent Death Benefit under your 4 Ever Life Insurance Company group term life coverage allows you to receive an early payment of a portion of your life insurance during your lifetime, if you meet certain requirements. You may elect the Imminent Death Benefit just once in your lifetime. The Imminent Death Benefit will be paid to you in one lump sum.

- The receipt of an Imminent Death, or accelerated, benefit under your group term life coverage with 4 Ever Life Insurance Company may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. If you meet the definition of a "terminally ill individual", according to the Internal Revenue Code Section 101, your Imminent Death Benefit may be non-taxable. You should consult your personal tax advisor and/or legal advisor before you apply for an Imminent Death Benefit.

- To be eligible for this benefit, you must have a medically determinable condition which is expected to result in death within 6 months of your signing the Imminent Death Benefit Employee's Claim Form (one of the attached forms). If you are eligible, you may elect to receive up to _____% of your 4 Ever Life Insurance Company group term life insurance benefits paid to you during your lifetime. If _____% of your benefit exceeds $_______, then the accelerate benefit is limited to $______. The remainder of your 4 Ever Life Insurance Company group term life insurance benefits will be paid to your designated beneficiary upon receipt of claim at the time of your death.

- In order to apply for this benefit, the attached forms must be completed and returned to your plan's administrator at the address below. All of the questions on all of these forms are important and need to be answered to the best of your ability and as completely as possible. If a question does not apply to you or your situation, please indicate this and explain why.

c/o Bay Bridge Administrators
P.O. Box 161690
Austin, TX 78716
(800) 845-7519

Form # 1 is the Employee's Claim Form/Consent to Payment. You, the insured, must fill out this form completely, sign it, and date it. If you need additional space, please use an additional sheet of paper and attach it to the form. An incomplete form will be returned to you.

Form # 2 is the Authorization to Obtain Information. Please sign and date this form and attach it to Form # 1 so that the necessary information may be obtained in order to determine your eligibility for this benefit. The authorization also allows 4 Ever Life Insurance Company to release information to other parties for the purposes which are specified on the Authorization. You will receive a copy of this Authorization if you request one.

Form # 3 is the Attending Physician's Statement. This form is to be completed by both you and your Attending Physician. Part A should be completed by you. The rest of the form is to be completed by your Attending Physician. If you have seen more than one physician for the condition which is causing you to exercise this benefit, a statement should be completed by each physician. Once completed, your physician(s) should mail the form directly to the plan's administrator at the address shown.

Form # 4 is the Employer's Statement. This form is to be completed only by your employer. Once completed, this form is to be returned to the plan's administrator at the address shown directly by your employer.

It is your responsibility to make sure that all of the forms in this package are completed and returned to the plan's administrator for processing. Nothing can be done regarding your claim until all of the four completed forms are received. Should you have any questions, please direct them to the plan's administrator at the address above.

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716
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IMMINENT DEATH BENEFIT
AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, healer, medical practitioner, or health care provider.
- Any hospital, clinic, pharmacy, or other medical or medically related facility, or association.
- Any insurance company.
- Any employer or plan administrator.
- Any government agency, including the Social Security Administration.
- Any organization or entity administering a benefit program.
- Any educational, vocational, or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.

TO GIVE THIS INFORMATION:

Chart notes, x-rays, operative reports, lab and medication records, and all other medical information about me, including medical history, diagnosis, testing and test results, prognosis and treatment of any physical or mental condition, including:

- Any disorder of the immune system including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including test results.
- Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.
- Any non-medical information requested about me, including such things as: education, employment history, earnings or finances, or eligibility for other benefits.

TO 4 EVER LIFE INSURANCE COMPANY, THE PLAN ADMINISTRATOR, AND THE POLICYHOLDER.
I understand that 4 Ever Life Insurance Company will use the information to determine my eligibility for insurance benefits.

4 Ever Life Insurance Company may release information about me to a reinsurer, a plan administrator, the policyholder, or any person performing business or legal services for 4 Ever Life Insurance Company in connection with my claim.

I ACKNOWLEDGE THAT I HAVE READ THE AUTHORIZATION AND I UNDERSTAND AND AGREE THAT THIS AUTHORIZATION SHALL REMAIN IN FORCE THROUGHOUT THE DURATION OF MY CLAIM FOR BENEFITS WITH 4 EVER LIFE INSURANCE COMPANY. A photocopy of this authorization is as valid as the original.

Name: ____
Please Print

____ ____________________
Signature of Claimant/Guardian/Representative Date

You have a right to receive a copy of this authorization upon request.

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716
(800) 845-7519

IMMINENT DEATH BENEFIT
CONSENT TO PAYMENT OF IMMINENT DEATH BENEFIT

SS.

STATE OF ______________________)

County of _______________________)

The undersigned, on oath being first duly sworn depose and say:

My relationship to ____ is:

- ☐ spouse living in a community property state
- ☐ assignee under an assignment
- ☐ irrevocable beneficiary
- ☐ trustee in bankruptcy or other official of the Bankruptcy Court

I understand that the claimant is making application to 4 Ever Life insurance Company for the payment of an Imminent Death Benefit in the amount of $______________under a group term life insurance policy. I consent to the payment by 4 Ever Life Insurance Company to claimant of the Imminent Death Benefit should the claimant be determined to be eligible.

Signature ____

Subscribed and sworn to before me this ________________ day of ___________________, _____________
(month) (year)

Notary Public for the state of ________________________

My commission expires: ___________________________