Madison National Life
Insurance Company, Inc.

Bay Bridge Administrators
Attn: Group Life Claims
P.O. Box 161690 AUSTIN, TX 78716
Telephone: 800-845-7519

ACCELERATED DEATH BENEFIT / LIVING BENEFIT CLAIM FORM

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

EMPLOYER'S STATEMENT

Employer's name:_____ Group/Policy number:_____

Name of employee:_____ Social security number:_____

Employee's address:_____
Street City State Zip Code

Employee's date of hire:_____ Employee's occupation:_____

Is the employee currently working? ☐ No ☐ Yes If no what was his/her last day of work?_____

Average number of hours employee worked/week: _____

Employee's annual salary:_____ Was the employee retired? ☐ No ☐ Yes Date_____

Amount of Coverage

Group Voluntary Term Life to Age 120: $ _____ **Accidental Death: $** _____

Dependent Group Term Life: $ _____

Name and title of individual completing this form (please print): _____

Email address:_____

Telephone number: _____ Fax number:_____

Signature_____Date_____

EMPLOYEE'S STATEMENT

Name (please print)_____

Address:_____
Street City State Zip Code

Telephone Number_____ E-mail Address_____

Date of birth: _____ ☐ Male ☐ Female Height _____ Weight _____ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school and (3) disabled children regardless of age if their disability began before age 22).

_____

_____

Please indicate the diagnosis which you believe will qualify you to receive Accelerated Death / Living benefits: _____

_____

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: 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.

CALIFORNIA WARNING: 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.

COLORADO WARNING: 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 damage. 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.

DISTRICT OF COLUMBIA 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.

FLORIDA WARNING: 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.

KENTUCKY WARNING: 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.

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

NEW HAMPSHIRE WARNING: 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 RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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.

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

Signature: _____ Date: _____

DISCLOSURE STATEMENT REGARDING ACCELERATED DEATH / LIVING BENEFITS

IMPORTANT: YOU MUST READ (OR HAVE READ TO YOU), UNDERSTAND, AND, WHERE APPLICABLE, AGREE WITH THE INFORMATION CONTAINED BELOW BEFORE YOU DECIDE WHETHER TO REQUEST THE ACCELERATED DEATH / LIVING BENEFIT PAYMENT.

The accelerated death / living benefit is a benefit payable under the Policy's Employee Only Life Insurance Coverage to an insured employee during his or her lifetime. The benefit amount is determined based on a specified portion of the employee's basic group life insurance benefit in effect on the accelerated death / living benefit payment date. The company will charge interest and certain administrative fees, as outlined below.

Only those insured employees meeting all the conditions described in the Policy's accelerated death / living benefits provision (or Endorsement) may elect this benefit option. Benefit payment is not automatic; you must elect to receive the accelerated benefit by completing and providing the Company with all the required documents and proofs as described in such provision. No payment will be made unless and until the Company receives and approves of your election.

Please carefully consider the following important aspects of accelerated death / living benefit:

1. Receipt of the accelerated death / living benefit payment by you or your designated assignee(s) could be taxable as income to you. We advise that you seek assistance from a competent tax advisor before you decide to elect this option.
2. Receipt of the accelerated death / living benefit payment may adversely affect the recipient's eligibility for Medicaid or other federal or state government benefits or entitlement.
3. The accelerated death / living benefit payment will reduce the face amount of the basic life insurance benefit, and thus reduce correspondingly the life insurance proceeds payable to your beneficiary (ies) upon your death. The reduction will be equal to the sum of the following amounts:

    (a) an amount paid under the accelerated death / living benefit option; plus
    (b) an interest charge on the benefit amount paid commencing the payment date of your death, calculated at the interest rate described in 4 below

4. The Company will charge interest on the accelerated death / living benefit at the rate of _____% per annum. The interest for the first 12-month period will be determined and charged in advance. The Company will make an interest adjustment upon your death. (If the insured dies before the end of the first 12-month period, the company will refund the unearned portion of the interest charged. If the insured dies after the end of the first 12-month period, the company will assess against the remaining life insurance proceeds the interest accrued after the end of the first 13-month period.)
5. The Company's approval or payment of the accelerated death / living benefit does not operate to waive the required monthly premium payment for your remaining life insurance, accidental death and dismemberment, and any other insurance coverages. You and/or your employer must continue paying the required monthly premium to keep in force such insurance coverages. Failure to do so will cause such insurance coverages to end.
6. The Company reserves the right to periodically evaluate your health and medical conditions. It may require you to be examined, but not more than once in any six-month period, by a physician(s) of our choice at our expense.

I have read (or been read) and understand the above Disclosure Statement and agree, on behalf of myself, my life insurance beneficiary(ies), heirs, executors, administrators and assignees, to abide by the conditions and requirements described in this document.

Further, I agree to have this Disclosure Statement attached to and made part of my ELECTION AND AGREEMENT FORM FOR ACCELERATED DEATH / LIVING BENEFIT.

Signature _____ **Date** _____

ELECTION AND AGREEMENT FORM FOR ACCELERATED DEATH / LIVING BENEFITS

I am hereby submitting to Madison National Life Insurance Company, Inc. (hereafter "the Company") my election to receive the accelerated death / living benefit on _____% of the amount of my group voluntary term life to age 120 insurance.

I have read (or been read), understand and agree with the Company's Disclosure Statement. In addition, I agree to the following, and, where applicable, represent and certify them to be true to the best of my knowledge and belief:

1. I have not made an absolute or irrevocable benefit assignment or transferred ownership of any portion of my life insurance benefits. I agree to refrain from making such assignment or transfer.

2. I have not designated any person or entity as irrevocable beneficiary(ies) of my life insurance benefits, and agree to refrain from making such beneficiary designation.

3. I understand that the Company's receipt of this election does not obligate the Company to grant the accelerated death / living benefit payment unless and until the Company approves my election.

4. In consideration of the Company's payment of the accelerated death / living benefit on upon its approval of my election, I agree, on behalf of myself, my life insurance beneficiary (ies), heirs, executors, administrators and assignees that the company is released and discharged from any and all claims for the portion of my life insurance benefits contributory to the company's payment of the accelerated death / living benefit and the interest and fees charged. I agree to defend the Company and hold it harmless against any and all claims, demands and causes of action arising out of or in connection with said portion of my life insurance benefits.

5. To supplement and clarify the Agreement I am entering into with the Company as a result of my election, I agree that the Company's Disclosure Statement is to be attached to and made part of this Election and Agreement form.

6. I agree to provide my authorization to the Company to obtain any and all information regarding my physical and mental condition, medical treatments and laboratory test results which the Company deems necessary for its approval process.

7. I am of sound mind and making this Election and Agreement with my own free will without any constraint or undue influence.

Signature_____**Date**_____

If you reside in Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin, your spouse also must sign this form:

Spouse signature_____Date_____

Subscribed and sworn before me, a notary public, on _____, 20_____,

by _____ to me personally known.

Notary _____

SEAL

My commission expires: _____

BENEFICIARY (IES) CONSENTING STATEMENT ON INSURED'S ELECTION OF ACCELERATED DEATH / LVING BENEFITS

My assigned beneficiaries are as follows:

Primary Beneficiary (ies)

In the event of my death, I request that benefits be paid as follows:

Full Name	Relationship	Percentage of Benefit

Contingent Beneficiary (ies)

In the event that none of my primary beneficiaries are living at the time of benefit payment I request that benefits are paid as follows:

Full Name	Relationship	Percentage of Benefit

I (We), a beneficiary(ies) designated for the insured's "Employee Only Life Insurance" benefits, am (are) hereby submitting to Madison National Life Insurance Co., Inc. (hereafter "the Company") my (our) consent to the insured's accelerated death / living benefit election of _____% of the amount of his/ her group voluntary term life to age 120 insurance.

I (We) have read (or been read), understand and agree with the Company's Disclosure Statement regarding accelerated benefits and the possible effects of the insured's election of such benefit.

In addition, I (we) agree to the following:

1) The accelerated death / living benefit payment will reduce correspondingly the face amount of the insured's basic life insurance benefits. This will result in reduced life insurance proceeds payable to the beneficiary (ies) upon the insured's death.
2) The insured's election together with the Company's payment of the accelerated death / living benefit constitute a valid and effective beneficiary designation change, but only with respect to the life insurance benefits, and only to the extent affected by the accelerated death / living benefit payment and the interest and fees charged thereon.
   If there are two or more designated beneficiaries, each such beneficiaries' proportionate share of the remaining life insurance proceeds will remain the same as his/her proportionate share in the insured's life insurance benefits in effect immediately before the accelerated death / living benefit on payment, subject to any beneficiary designation change in effect at the time of the insured's death.
3) The Company's Disclosure Statement regarding accelerated death / living benefit on is to be attached to and made part of the Consenting Statement Form.

BENEFICIARY 1

Name_____
Date of Birth _____Relationship_____
Social Security Number_____
Complete Address_____

_____

Signature Date

BENEFICIARY 2

Name_____
Date of Birth _____ Relationship_____
Social Security Number_____
Complete Address_____

_____

Signature Date

BENEFICIARY 3

Name_____
Date of Birth _____Relationship_____
Social Security Number_____
Complete Address_____

_____

Signature Date

BENEFICIARY 4

Name_____
Date of Birth _____ Relationship_____
Social Security Number_____
Complete Address_____

_____

Signature Date

Signature of employee _____ **Date**_____

If you reside in Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin, your spouse also must sign this form:

Spouse signature _____ **Date** _____

Madison National Life

Insurance Company, Inc.

Bay Bridge Administrators

Attn: Group Life Claims

P.O. Box 161690 AUSTIN, TX 78716
Telephone: 800-845-7519

Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ Date of birth: _____ Telephone number: _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

5) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: **Madison National Life Insurance Company (address, telephone and fax number documented above)**

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2009 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2009 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature_____ **Date**_____

Madison National Life
Insurance Company, Inc.

Bay Bridge Administrators
Attn: Group Life Claims
P.O. Box 161690 AUSTIN, TX 78716
Telephone: 800-845-7519

ACCELERATED DEATH / LIVING BENEFIT PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

We are in the process of evaluating a claim for Accelerated Death / Living Benefits for your patient. In order to determine benefit eligibility, we must request that this form be completed in detail. This form must be completed by a physician.

Name of patient:________________________ Date of birth________________________

Address:____
Street City State Zip

Social security number:________________________ Telephone number:________________________

Name of employer:________________________ Occupation:________________________

DIAGNOSIS

Primary diagnosis:________________________ ICD-9 code:________________________
Secondary diagnosis:________________________ ICD-9 code:________________________
Other diagnoses and ICD codes related to this claim:________________________
____
____

Symptoms:____
____
____

Is your patient competent to endorse checks and direct the use of the proceeds thereof? No ☐ Yes

According to the terms of the Policy, "Terminal Illness" is defined as "a medical condition for which there is no known medical treatment that would extend a patient's life and which could be expected in at least eighty percent of cases to result in death within twelve to twenty four months or less."

In your opinion, does your patient currently meet the above indicated definition of "Terminal Illness"? ☐ No ☐ Yes If yes, please provide the following:

Date diagnosis which qualifies as a "Terminal Illness" was made:________________________

Current treatment plan:____
____

At this time, the goal of care is: ☐ Cure ☐ Palliation ☐ Control ☐ Symptom management

Please check the box which best indicates your estimate of the patient's life expectancy:
☐ 0 to 6 months ☐ 6 to 12 months ☐ 12 to 18 months ☐ 18 to 24 months ☐ More than 24 months ☐ Unable to determine life expectancy

Briefly describe the medical findings used to determine both the terminal diagnosis as well as the severity of the condition:________________________
____
____

PLEASE READ CAREFULLY

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF ALL MEDICAL RECORDS PERTAINING TO THIS DIAGNOSIS INCLUDING LABORATORY DATA AND RESULTS OF DIAGNOSTIC TESTS CONFIRMING THE DIAGNOSIS AND SEVERITY OF THE CONDITION, OFFICE VISIT NOTES, SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THE PAST SIX MONTHS. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

Physician's signature:________________________ Date:________________________

Physician's name (please print)________________________ Specialty:________________________

Address:________________________ City:____________ State:____________ Zip Code:____________

Phone number:________________________ Medical record department fax number:________________________