QualChoice® HEALTH INSURANCE

Accelerated Life Insurance Claim Form

Underwritten by QualChoice Life and Health Insurance Company, Inc.

IMPORTANT — Read Carefully: This form is to be fully completed by the claimant, physician, and employer and forwarded to QualChoice at the below address. Along with the completed form, W-2 and/or payroll records are also required. The patient is responsible for the completion of this form without expense to QualChoice. Proof of terminal illness certified by the attending physician and one other physician must be provided as well.

NOTE: Only active, full-time employees are eligible for group life insurance products. Part-time or retired employees are not eligible for coverage unless a special provision has been provided for in your group life insurance policy.

PLEASE PRINT

Part I. TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

	Group Policy Number:	ID Number:	
1	Name of Insured:	Insurance Class:	Amount of Insurance: $
2	Address:	Phone:	Date of Birth (MM/DD/YYYY):
3	Date Total Disability Began (MM/DD/YYYY):	Cause of Disability:	
4	Date Employed (MM/DD/YYYY):	Job Title:	
5	Date on which the insured last worked full-time (MM/DD/YYYY):		
6	Has this employee or member's insurance been terminated? ☐YES ☐NO	If "**YES**," show date of termination (MM/DD/YYYY)	
	Reason:	Has this employee or member's insurance been converted? ☐YES ☐NO	
7	IF GROUP POLICY ISSUED TO A UNION OR TRUSTEE PLAN, PLEASE ANSWER THE FOLLOWING QUESTIONS: a. Date on which the insured became a member (MM/DD/YYYY):______________ b. Date on which the insured terminated membership (MM/DD/YYYY): ______________ c. Was the insured a member in good standing on the date disability began? ☐YES ☐NO		

Date (MM/DD/YYYY):	Name of Group Policyholder:	By:	Title:
Phone:	Email Address:		

Part II. TO BE COMPLETED BY EMPLOYEE

1	Date when your health first began to be affected (MM/DD/YYYY):	On what date did you become totally disabled so as to be prevented from doing any work? (MM/DD/YYYY):
2	Describe fully the nature of your disability and its cause:	
3	Are you now totally disabled and unable to work? ☐YES ☐NO	Briefly describe your present-day activities:

4 What physicians have you consulted during your present disability?

Name	Address	Phone	Dates (From & To)
Name	Address	Phone	Dates (From & To)

Part III. MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, governmental agency, Medicare Part A and Part B carrier, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of the above named insured's health, including information relating to mental illness, use of drugs or alcohol, to give QualChoice Life and Health Insurance Company, Inc., or their reinsurers any such information. A copy of this authorization shall be considered as effective and valid as the original.

I CERTIFY THE ABOVE AS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Claimant/Beneficiary:	Phone:	Date (MM/DD/YYYY):

Part IV. PHYSICIAN INFORMATION

1. Date of First Visit (MM/DD/YYYY):	2. Date of Last Visit (MM/DD/YYYY):	3. Date Total Disability Began (MM/DD/YYYY):
4. Diagnosis:	5. ICD-10-CM Disease Code:	6. Present Condition:

7. Objective findings. Include any results of current X-rays, EKGs, or any other special tests:

8. List any hospital confinements for this disability:

Name of Hospital:	Period Confined From (MM/DD/YYYY): To (MM/DD/YYYY):

9. To qualify for this benefit, your patient must have a life expectancy of 12 months or less. Does you patient meet this requirement? ☐YES ☐NO

10. Stage of Cancer (if applicable):	11. Metastasis? ☐YES ☐NO	If "**YES**," where?	12. Hospice? ☐YES ☐NO

Physician Address:

Signature:	Date (MM/DD/YYYY):