LeadersLife INSURANCE COMPANY

Accelerated Benefits Claim Form

SECTION I

Full Name of Insured _____ Policy Number(s) _____ Social Security Number _____

Residence Address of Insured _____ City _____ State _____ Zip _____

Phone Number _____ Alternate Phone Number _____ Date of Birth _____

SECTION II

When did insured first complain or give other indications of this illness? _____

Name/Addresses or phone numbers of all physicians or practitioners that insured consulted within the past five years:

Name	Address	Phone Number	Date of Attendance	Disease/Condition

SECTION III

The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policies numbered above. Any physician or practitioner who has attended the ablove Insured, and/or any hospital (including Veterans Administration Hospital) or other institution in which the Insured was treated or confined, is hereby authorized to furnish to Leaders Life Insurance Company or its representatives, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions or treatments pertaining to the above Insured. Such information may be included as part of the proofs of the incident submitted to the Company. *I further understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).*

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.
Applicable to **OK** residents: 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.
Applicable to **AR** and **LA** residents: Any person who knowing 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.
Applicable to **KS** residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.
Applicable to **AL** residents: 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.
Applicable to **FL** residents: 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.
Applicable to **NM** residents: 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 CIVIL FINES AND CRIMINAL PENALTIES.
Applicable to **TX** residents: Any person who knowingly presents a false of fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If either the named insured or policyowner is incapacitated and unable to sign this form, the current power of attorney must sign and the form must be notarized.

Print Name of Insured _____ Signature of Insured _____ Date _____

Print Name of Policy Owner _____ Signature of Policy Owner _____ Date _____

Mailing Address of Policy Owner _____ City _____ State _____ Zip _____ Phone Number _____

Dated at _____ (City & State) This _____ (Day) Day of _____ (Month & Year)

If claim is compensable, pay by: ☐ Check ☐ Bank Deposit
(Please complete attached Direct Deposit Form.)

NOTARY

State of _____, County of _____ On this _____ day of _____ personally appeared before me the above named _____ who is know to me and who subscribed the foregoing statement before me and made Oath that the foregoing answers are each and all complete.

SEAL

Notary Signature _____ My Commission Expires _____