RESET

PACIFIC GUARDIAN LIFE

Group Accelerated Death Benefit Claim Form

For your protection California laws and the laws of some states require the following to appear on this form: Any person who knowingly presents 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.

To process this claim as quickly and accurately as possible, each section must be completed by the proper person and all information provided as requested. If anyone has questions on how to complete the form, contact our Group Claims Department at (808) 955-2236 from Oahu; 1-800-367-5354 from U.S. Mainland and the Neighbor Islands.

A. TO BE COMPLETED BY INSURED/CLAIMANT (Please print clearly)

1. Name (First Name, Middle Initial, Last Name):

2. Street Address:

City: State: Zip:

3. Birthdate (mm/dd/yy): 4. Social Security No.: 5. Telephone:

B. AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I agree that Pacific Guardian Life or its representative may get or see a copy of any records or data which have to do with the physical or mental health and employment of (name of insured):

This information may be used by Pacific Guardian Life to determine that this claim is valid. A photocopy of this form is as valid as the original.

Signature of Insured: Signature of Witness:

If other than insured, state relationship, address and phone number:

C. TO BE COMPLETED BY EMPLOYER/POLICYHOLDER

1. Group Name: 2. Policy Number:

3. Insured employment date: 4. Eff Date of Coverage: 5. Date last worked full-time:

6. Is claimant eligible for insurance benefits? ☐ Yes ☒ No 7. Amount of Insurance:

8. Completed by (Print):

9. Signature: 10. Date:

D. ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (Must be completed by Attending Physician)

1. To qualify for this benefit the patient must have a life expectancy of six months or less.

Does your patient meet this requirement? ☐ Yes ☒ No

2. Diagnosis:

3. Date of most recent visit:

4. Date of onset of illness:

5. Is patient capable of handling his/her own affairs? ☐ Yes ☒ No

6. Present condition:

7. Objective findings (include results of current x-rays, EKG or any other special tests):

8. If patient is hospitalized, name and address of hospital:

Physician's Signature: Date: Telephone:

Physician's Address:

When all three portions of this form are completed, please send to:
Pacific Guardian Life, Group Administration Department, 1440 Kapiolani Blvd., Suite 1700, Honolulu, Hawaii 96814