TERMINAL ILLNESS BENEFIT RIDER CLAIM FORM

THE PURPOSE OF THIS CLAIM FORM IS TO FILE A CLAIM ON ONLY YOUR TERMINAL ILLNESS BENEFITS.

Please read the important information below:

Please be sure your policy number(s) is/are written on all documents.

United National Life will pay benefits under the Terminal Illness Rider upon a diagnosis of a terminal illness which is reasonably expected to result in death within the next 6 months. The benefit is available as of the date of your Physician's Certification that the prognosis of your illness is deemed terminal. Benefits will end on the earlier of: the date of death; or the date we have paid the maximum terminal illness benefit under the Rider.

We will require the treating physician for your illness completes the Physician's Certification on Page 3.

Benefit payments will begin 30 days AFTER the Physician's Signed Certification Date and paid on a monthly basis. Monthly payments will be made in arrears AFTER each month has been incurred and we verify the insured is living.

Assignment of Benefits Designation: All benefits for this Rider are presumed to be payable to you, UNLESS you Complete the Assignment of Benefits Designation (Page 4) to pay another on your behalf. Upon your death, if no designation, benefits will be made payable to your Estate.

The included HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated, and included with your submission. We will use this to contact your medical provider on your behalf if additional information is needed.

NOTE: Your policy has a Pre-Existing and Contestable Period. If your claim happened during either of these periods additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests on your behalf directly with your medical provider(s) and will notify you of our action or any delays.

We suggest that you make photocopies of any information that you submit and keep them for your own records.

The claim form must be completed and signed by the insured or responsible party. Please attach any Power of Attorney papers if applicable.

Please submit the completed claim form, and signed HIPAA Authorization, Physician's Certification and/or medical records to:

United National Life
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 699-1048
OR Email to: Claims@unlinsurance.com

For assistance, please contact our Customer Service Department (800) 207-8050

Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or fax to: (847) 699-1048
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SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders

COMPLETED BY THE INSURED

Policy Number(s) | Policy Holder's Name

Claimant/Patient Name | Date of Birth

Address (Street) (City) (State) (Zip Code)

Phone | Email

Date symptoms first appeared: ____/_____/_____ Date of first visit with physician: ____/_____/_____

Date of actual/definitive diagnosis: ____/_____/_____

Have you ever had this illness/condition before? ☐ Yes ☐ No If yes, what date: ____/_____/_____

If yes, what's the name, address and telephone number of physician that treated you? ________________________________

____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center: ____________________

____

Physician treating you for this terminal illness: (This is the same doctor to complete Physician's Cert. on page 3)

Physicians name | Address | Telephone Number

Were there any other physicians seen during the last two (2) years? *(if more space is needed, please attach separate sheet)*
If so, please provide their names, addresses and phone numbers:

Physicians name | Address | Telephone Number

Physicians name | Address | Telephone Number

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Glenview, Illinois 60025
Or fax to: (847) 699-1048
Or email to: Claims@unlinsurance.com
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PHYSICIAN'S CERTIFICATION

Name of Insured/Patient: ____ Policy Number:________________________

To be completed by physician treating insured for their terminal illness:

Please identify the medical condition the insured is diagnosed with: ____

____

Please provide the correlating ICD code for this condition: ____

What is the date of the initial diagnosis of this condition: ______/______/______

What is the insured's prognosis for recovery with this condition: ____

____

Date the insured (or legal representative) was advised of this prognosis: ______/______/_______

Do you certify that there is no cure for this condition or, that the insureds physical state is such that it does not allow for treatment of this condition? ☐ Yes ☐ No

Please provide us with the current estimated life expectancy for this patient: ____________________

On what date was this determined: ______/______/______

Physician's Name: __________________________________

Physician's Signature: ________________________________

Date of certification: ______/______/______

United National Life
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 699-1048
OR Email to: Claims@unlinsurance.com

UNL-TICF 1-22

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ASSIGNMENT OF BENEFITS

If you wish to have benefits paid to you, there is no need to complete this form. The Assignment of Benefits Designation is ONLY necessary if you are assigning the payment of your benefits to another.

Insured Name: ____ **For Policy Number:** ____

☐ Yes, I would like to assign the payment of benefits of my Terminal Illness Benefit Rider.

I, the undersigned, irrevocably assign to the below designated named assignee, all my rights and benefits under the Terminal Illness Benefit Rider. I understand that this document is a direct assignment of my rights and benefits that would otherwise be payable to me.

Designated Assignee Name: ____

Assignee Payment Address: ____
(No P.O. Box) Street City State Zip Code

How do you know the Assignee? _________________________

** Benefit payment will begin 30 days AFTER the Physician's Certification Date and are paid on a monthly basis. The monthly benefit payments will be made in arrears after each month has been incurred and we have verified the insured is still living.*

****

Signature of Assignee accepting payments: ____

Assignee SS#:_______________________ Assignee Date of Birth: ______/______/______

**Please be advised that there are potential tax implications for the Informal Caregiver benefits being paid to the Assignee. Prior to selecting benefits to be paid to an Assignee, such a person should be aware of the potential tax consequences and advised to consult with a personal tax advisor. United National Life Insurance Company of America or its agents cannot provide advice about this.*

Print Name of Insured/or Person Legally Responsible: ____________________________________ Date:_____/______/______

Signature of Insured/or Person Legally Responsible: _____________________________________ Date: _____/______/______

If you are person legally responsible, state relationship to Insured: ____ **
** Power of Attorney papers will be required

This Assignment of Benefits Designation will remain in effect until the earlier of: the date the maximum benefits have been exhausted, upon the insured's death, or we receive a written request from the insured to discontinue or change the designation.

United National Life Insurance Company of America
P.O Box 1144, Glenview, Illinois 60025
1-800-207-8050

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by UNL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # ______________________________

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide United National Life Insurance Company of America (UNL) or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that United National Life Insurance Company of America may condition payment of a claim upon my signing of this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by UNL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

____

(Print Please) Name of Patient — Date of Birth

____

Signature of Patient — Date

____

(Please Print) Name of Authorized Representative, or Next of Kin

____

Relationship of Authorized Representative or Next of Kin to Patient

____

Signature of Authorized Representative or Next of Kin — Date

Dear Insured: *Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

Generic Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama – 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.

Alaska – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - 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.

Arkansas, Louisiana, Rhode Island and West Virginia – 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 fines and confinement in prison.

California – For your protection California law requires 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.

Colorado – 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 damages. 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.

Delaware – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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 – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A 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.

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

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

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – 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 – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico – 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.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – 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.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files 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 subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington State – 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.

Texas – 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.