



Notice of Claim/Accelerated Benefit Living Benefit

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
PO Box 810
Greenfield, MA 01302-0810

Attention: Group Life Benefits

Must Be Completed In Full

Employer's Statement

Name of Claimant (Last, First, M.I.) - PLEASE PRINT			Basic Annual Earnings at Time of Disability \$	Date of Last Salary Change / /
Group Account Number	Effective Date of Full-Time Employment / /	Effective Date of Employee's Insurance / /	Occupation	
Amount of Employee's Insurance Basic Life \$	Supplemental/Voluntary	Date Last Worked / /	Has employee returned to work? (If "Yes," give date) <input type="checkbox"/> Yes _____ <input type="checkbox"/> No	Have premiums ceased? (If "Yes," give Date) <input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Reason for Leaving Work <input type="checkbox"/> Retired <input type="checkbox"/> Absent on Sick Leave <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Absent Because of Temporary Layoff <input type="checkbox"/> No Longer Employed				

Important Notice: If on file in your office, please provide us with a copy of the Employee's Enrollment Card, along with any subsequent change of beneficiary or benefit election forms.

Name of Employer	Telephone Number	
Address (No., Street, City, State, ZIP Code)	Fax Number	
Signature (Authorized Personnel)	Please Print or Type Name and Title of Authorized Personnel	Date Signed

Employee's Statement

Date of Birth	Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Last Worked	Telephone Number
Address (No., Street, City, State, ZIP Code)				

Please check only one: <input type="checkbox"/> I elect to receive the accelerated benefit on my Basic Life only. <input type="checkbox"/> I elect to receive the accelerated benefit on my Supplemental/Voluntary Life only. <input type="checkbox"/> I elect to receive the accelerated benefit on both my Basic and my Supplemental or Voluntary Life.	Is this policy subject to any provisions of a divorce decree? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there an irrevocable beneficiary on this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, the consent of the irrevocable beneficiary must be obtained agreeing to the payment of the advance benefit in a form which is satisfactory to us.
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Describe the condition which is the basis for applying for benefits under the accelerated benefit option.

Names and addresses of all attending physicians/hospitals who treated you for this illness.	Date you first consulted a physician for this condition.
	If you feel additional information would be helpful, please submit it on a separate piece of paper.

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give such information to GE Group Life Assurance Company (the Company) and its legal representatives: Any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group policyholder or certificate holder.

I understand that the information released to the Company will be used in evaluating my claim for insurance benefits. The Company may redisclose such information for that purpose to the employer or union connected with the group insurance coverage involved herein, the group policyholder or certificate holder or their representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of the Company. This information may also be redisclosed as otherwise specifically permitted or required by law.

This authorization extends to and includes any information relating to alcohol or drug abuse or mental health care. If the record contains information relating to HIV test results, AIDS, alcohol or drug abuse, or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested. This authorization or a photocopy of it will be valid for the duration of the claim. The information released to the Company will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee	Date Signed
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State Law, in some states, requires the following: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. **VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.**

Application for Accelerated Benefit Option (Living Benefit)

Group Account Number | Insured's Name | Date of Birth

TO THE PHYSICIAN: The insured is requesting an advance payment of life insurance proceeds due to terminal illness. Your statements are needed to determine eligibility for this advance payment.

History

When did symptoms first appear or accident happen? | Date of Initial Diagnosis | Date of Last Visit

Diagnosis

List diagnoses including complications, if any.

Please give current patient status including any objective findings which can include: current x-rays EKG's and laboratory data (if available, please provide copy of your clinical notes.) PLEASE NOTE: Additional information can be submitted at your discretion.

Is this condition terminal? Yes No How long do you expect patient to live?

Has patient lost the ability to perform two or more Activities of Daily Living? Yes No

On what date did patient become unable to perform two or more of the Activities of Daily Living?

Please check off all Activities of Daily Living that patient is unable to perform without substantial assistance from another person:

- bathing eating dressing toileting transferring continence

Comments:

Treatment

Nature of treatment, including surgery and medications prescribed.

Progress

Since the initial diagnosis, the patient's condition is: improved unchanged worse Patient is: ambulatory house confined bed confined nursing home/hospital confined

Date of hospitalization:

Name and address of hospital/nursing facility

Competency

Is the patient competent to endorse checks and direct the use of proceeds? Yes No To the best of your knowledge, has a guardian or conservator been appointed? Yes No Unknown

Physician's Verification

Name of Attending Physician (Please Print) Address Phone Number

Attending Physician's Signature Date Signed