Multinational Life Insurance Company
— Seguro te Responde —

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ACCELERATED LIFE BENEFIT REQUEST

PART A:

In order to qualify for this benefit, I understand that I must be terminally ill with a life expectancy of 12 months or less from the date of this request. This being the case, I hereby request an Accelerated Life Benefit payment under the Life Insurance Policy No. _____ issued to _____
(POLICYHOLDER/EMPLOYER)

Name of insured: _____

Address: _____

_____

Most recent hospitalization date: Month _____/ Day_____/ Year_____

Name and address of physician: _____

_____

Describe in your own words, your understanding of your health (condition): _____

_____

I hereby certify that the information provided above is true and correct to the best of my knowledge and belief.

Signature of insured: _____ Date of request: _____

Signature of witness: _____

AUTHORIZATION:

I hereby authorize any hospital, physician, or other person who has attended me, to furnish Multinational Life Insurance Company or its representatives, any and all information, including medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records with respect to the terminal illness listed on this Accelerated Life Benefit Request form. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the benefits under Policy No. _____. I understand and agree this authorization shall be valid for the duration of the claim. I understand that my authorized representative or I may ask for and receive a copy of this authorization.

Signature of insured: _____

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company or other person, files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

PART B:

Physician's Statement:

The patient is requesting an advanced life insurance benefit. Your statement is required to determine the patient's eligibility.

1. a. When did symptoms first appear or accident ocurred? Month _____ / Day _____ / Year _____
   b. Date the patient was informed of diagnosis: Month _____ / Day _____ / Year _____
   c. Has the patient ever had the same or similar condition? Yes ☐ No ☐
      If Yes, Month _____ / Day _____ / Year _____

2. a. Is patient's condition terminal? Yes ☐ No ☐
   b. If Yes, is life expectancy 12 months or less? Yes ☐ No ☐
   c. Diagnosis (including any complications): _____
   d. Subjective symptoms: _____
   e. Objective findings (including current X-rays, EKG's, laboratory reports, and any clinical findings): _____
   f. In your opinion, has this condition affected the mental capacity of the patient? Yes ☐ No ☐
   g. Other comments: _____

3. Dates of treatment: _____
   First visit: Month _____ / Day _____ / Year _____
   Last visit: Month _____ / Day _____ / Year _____
   Frequency: _____

4. Nature of treatment (including surgery and medications prescribed, if any):

5. Has patient: recovered? ☐ improved? ☐ remained unchanged? ☐ retrogressed? ☐

Print physician's name	Degree	Specialty	Telephone No.

Street address	City	State or Province	Zip Code

I hereby certify that to the best of my knowledge, information, and belief, the information provided herewith is true and correct.

_____
Signature of attending physician