

# Application for Accelerated Benefits

(TO AVOID DELAY PLEASE ANSWER ALL QUESTIONS)

LifeWise Assurance Company  
P.O. Box 2272  
Seattle, WA 98111-2272  
(425) 918-4575

# LIFEWISE

**ASSURANCE COMPANY**

Life | Disability | Stop Loss

**PLEASE PRINT**

EMPLOYEE			
1. FULL NAME (Last, First)		SOCIAL SECURITY NUMBER	
2. ADDRESS		CITY STATE ZIP	PHONE NUMBER ( )
3. DATE OF BIRTH (Mo. Day Yr.) / /	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	4. OCCUPATION (List the duties of your occupation at the time of disability)	
5. MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed In community property states, written consent of the spouse will be required when applying for Accelerated Benefits.			
6. I have been unable to work because of this disability since (Mo/Day/Yr.) / /			
7. Date of your accident or the date you first noticed the symptoms of your illness (Mo/Day/Yr.) / /			
8. Describe how and where accident occurred or describe the first symptoms of your illness _____			
9. Date you were first treated for your illness or injury / / (Mo. Day Yr.)		Treated By: Hospital: _____ Name Address Doctor: _____ Name Address	
10. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No / / (Mo. Day Yr.)		Treated By: Hospital: _____ Name Address Doctor: _____ Name Address	
11. BENEFICIARY INFORMATION			
NAME OF BENEFICIARY		RELATIONSHIP	TELEPHONE ( )
ADDRESS OF BENEFICIARY (STREET, CITY, STATE, and ZIP CODE)		DATE OF BIRTH OF BENEFICIARY / /	
		SOCIAL SECURITY NUMBER	
12. SPOUSAL CONSENT - Must be signed by spouse if employee is residing in a community property state. I hereby acknowledge and give my consent for application of the Accelerated Benefits. / / DATE SIGNATURE OF SPOUSE			

13. OPTIONAL MODES OF PAYMENT:

An interest bearing money market account (Insured Benefit Account) will be opened for you at State Street Bank and Trust Company, Boston, Massachusetts. Upon approval for payment of the benefits, you will promptly receive personalized checks and may **immediately** utilize all or a portion of those funds by writing checks against the account. The funds in the account, meanwhile, will earn interest at a competitive variable rate and will be insured for the full amount permitted by the FDIC. And, there are no monthly fees or service charges associated with the account. By signing below, you instruct LifeWise Assurance Company to transfer the settlement proceeds to State Street Bank and Trust Company and you authorize State Street Bank and Trust Company to obtain any references necessary, and to exchange information with LifeWise Assurance Company concerning your Insured Benefit Account. For a current quote on the interest being paid thereon, or for additional information regarding this or any other settlement option call (425) 918-4575. Benefits will be paid in this manner unless an optional mode of settlement is selected.

OPTION A: Insured Benefit Account, as described above.

OPTION B: Single Benefit Payment.

**UNDER PENALTIES OF PERJURY:** I certify (1) that the number shown on this form is my correct taxpayer identification number, and (2) that I am not subject to backup withholding as a result of a failure to report all interest or dividend, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (If subject to backup withholding, please cross out No. 2.)

The above Statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish the Insurance Company providing this form, or their representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Date / /

Signature  
of Employee **X**

**EMPLOYER**

1. EMPLOYEE'S NAME		SOCIAL SECURITY NUMBER	POLICY NUMBER	INSURANCE CLASS
2. EMPLOYEE'S DATE OF HIRE	EMPLOYEE'S EFFECTIVE DATE OF INS.	LAST DAY WORKED	REASON FOR STOPPING WORK	RETURNED TO WORK ON
/ /	/ /	/ / /		/ / /
3. OCCUPATION AT TIME OF DISABILITY (Attach copy of job description)			WORK SCHEDULE AT TIME OF DISABILITY	
			Days Per Week	Hours Per Day
4. BASIC MONTHLY EARNINGS				
Employer _____ Address _____				
Signed _____				
Title _____ Date _____ / _____ / _____ Phone No. ( ) _____				

**ATTENDING PHYSICIAN'S STATEMENT**

To be furnished without expense to LifeWise Assurance Company

NAME OF PATIENT		DATE OF BIRTH (Mo. Day Yr.)
		/ /
1. HISTORY		
(a) When did symptoms first appear or accident happen? (Mo/Day/Yr.) _____ / _____ / _____		
(b) Date patient ceased work because of disability (Mo/Day/Yr.) _____ / _____ / _____		
(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes" state when and describe (Mo/Day/Yr.) _____ / _____ / _____		
(d) Names and addresses of other treating physicians		
2. DIAGNOSIS (including any complications)		
(a) Date of last examination (Mo/Day/Yr.) _____ / _____ / _____		
(b) Diagnosis (including any complications) _____		
(c) Subjective symptoms _____		
(d) Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings) _____		
3. DATES OF TREATMENT		
(a) Date of first visit (Mo/Day/Yr.) _____ / _____ / _____		
(b) Date of last visit (Mo/Day/Yr.) _____ / _____ / _____		
(c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify) _____		
4. NATURE OF TREATMENT (including Surgery and Medications prescribed, if any)		
_____		
5. PROGRESS		
(a) Has patient <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?		
(b) Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined?		
(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from _____ / _____ / _____ through _____ / _____ / _____		
If yes, give Name and Address of Hospital _____		
6. PROGNOSIS		
(a) Is patient now totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date total disability started: (Mo/Day/Yr.) _____ / _____ / _____		
(b) Patient is terminally ill with a life expectancy of <input type="checkbox"/> over 12 months <input type="checkbox"/> 12 months or less from the date of disability.		
7. REMARKS		
NAME (Attending Physician) Print		TELEPHONE
		( )
STREET ADDRESS	CITY	STATE ZIP CODE
SIGNATURE		DATE
		/ /