☐ American-Amicable Life Insurance Company of Texas ☐ IA American Life Insurance Company
☐ Pioneer American Insurance Company ☐ Pioneer Security Life Insurance Company
☐ Occidental Life Insurance Company of North Carolina

POLICY NO. _____ P.O. Box 2549, Waco, TX 76702, 800-736-7311

NURSING HOME WAIVER OF PREMIUM CLAIM FORM

PART ONE: TO BE COMPLETED BY INSURED/POLICYOWNER

Please Note: Failure to complete this form IN FULL may delay payment of your claim. PLEASE PRINT.

1. Insured's Name: _____ 2. Insured's Date of Birth: _____
3. Policy owner/Certificate Holder: _____
4. Policy owner/Certificate Holder's Mailing Address: _____
   _____
5. Enter your taxpayer identification number. For most individuals this is your social security number_____
   CERTIFICATION – Under penalties of perjury I certify that:
   1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) and
   2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding.

   Policy owner/Certificate Holder's Signature: _____
6. Admitting Diagnosis: _____
7. Date of Admission to Facility:_____
8. When was the condition first diagnosed? _____
9. Is your physician a member of the Insured's/Owner/s immediate family? ____yes ____ no If yes, state your relationship.
   _____
10. Does the physician reside with the Accelerated Benefit insured or owner? ____ yes ____ no
11. First doctor consulted and date(s) of treatment: _____
    Date:_____
    All other doctor's consulted and date(s) of treatment:

Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
_____	_____	_____
Date: _____	Date: _____	Date: _____

CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical, professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, government agency including, but not limited to, the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agents, or legal representative, and any insurance support organization and consumer reporting agency acting on The Company's behalf, with any and all medical records and personal information requested about me or my minor children.
I UNDERSTAND THAT THIS Authorization will be used to obtain information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use of drugs or use of alcohol.
I UNDERSTAND the information obtained by use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy.
I KNOW that I or my legal representative may request to receive a copy of this Authorization.
I UNDERSTAND that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization at any time by requesting such in writing to the Company at the address shown above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date: _____

Signature of Patient/guardian/personal representative_____

Legal relationship to applicant: _____

Part Two: **ATTENDING PHYSICIAN REPORT**

Patient's Name: _____ Age: _____

NURSING HOME WAIVER OF PREMIUM BENEFIT

1. Admitting Diagnosis: _____

   _____

2. Onset Date: _____

3. First Consulted You on: _____

4. Other Diagnoses Treated in the Past Two Years

   _____ Date _____

   _____ Date _____

   _____ Date _____

5. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days? ☐ yes ☐ no

   If YES, expected period of illness: _____

6. Does patient require continual medical supervision? ☐ yes ☐ no

   If No, explain: _____

7. Was patient referred to you by another physician? ☐ yes ☐ no
   If YES, give name and address of referring physician.

   _____
   (Name of referring physician) (Address) (Area Code/Phone Number)

   Date _____ Signed _____
   (Fed Tax ID No.)

   Name of attending physician (Please print) _____

   _____
   (Street Address) (State/Zip Code) (Area Code/Phone Number)

Part Three: **To be completed by the Director of Nursing**

Policy Owner's Name: _____ Policy Number: _____

Patient's Name: _____ Social Security No. _____

1. Date of admission to this facility: _____
2. Is the patient a full time permanent resident? _____
3. Is the facility Medicare-approved skilled Nursing Facility? _____
4. What type of care are you licensed to Provide? _____

   License Number: _____

   ☐ Skilled ☐ Intermediate ☐ Custodial ☐ Personal ☐ Assisted Living ☐ Residential ☐ Respite ☐ Other
5. Describe the type of care administered. _____

   _____
6. Admitting Diagnosis: _____

   _____
7. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days? ☐ yes ☐ no

   If YES, expected period of illness: _____
8. Was patient confined to another facility or hospital prior to this admission? ☐ yes ☐ no

   If YES, give name and address of facility and dates of confinement:

   Facility _____ Date _____

   Facility _____ Date _____

_____

Signature of Director of Nursing Date

Name of Institution _____ Tax ID Number _____

Address_____ Phone Number ( ) _____

Important Notice
In some states we are required to advise you of the following: Any person, who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

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.

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 insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana – 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.

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.

Massachusetts – 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 state prison.

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy 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.

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 an application for insurance or 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.

Puerto Rico – Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Rhode Island – 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.

Tennessee – 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.

Virginia – Any person who, with the 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 may have violated state law.

Washington – 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.
In All Other States – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing a false or deceptive statement may be guilty of insurance fraud.