Accelerated Death Benefit (Standard Option)

******INSTRUCTION PAGE******

Enclosed please find:

- An Application for Accelerated Death Benefit
- A Request for Medical Documentation letter
- Two Authorizations to Release Information
- An Authorization to Obtain Information
- Attending Physician's Statement
- A sample letter to the employee
- An Accelerated Death Benefit Disclosure Statement
- An Accelerated Death Benefit Assignee Consent Form
- A Questions and Answer Sheet
- Accelerated Death Benefit Forms on File Server Guide

Steps to follow:

1. Complete the Employer section of the "Application for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.

2. The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" form and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" form to the Aetna. If the Employee previously completed an Absolute Assignment, the Assignee must authorize the Aetna to review the Accelerated Death Benefit claim and issue benefits to the insured. The employee must send the "Assignee Consent" form to the Assignee. The Assignee must complete the form and return it to Aetna. The completed forms may be mailed to**: Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352,** or faxed to: **608-258-3413.**

3. The employer will then mail or fax the prior two years enrollment forms to: **Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352,** or fax to: **608-258-3413.**

4. The employee is to then complete the "Request for Medical Documentation letter" and the remaining "Authorization to Release Information" form and send them to their physician(s) along with the Attending Physician's Statement.

5. The medical documentation should then be mailed or faxed to: **Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352,** or faxed to: **608-258-3413** along with a copy of the "Request for Medical Documentation letter".

If you have any Questions, please contact us at 1-800-236-5414, or locally at 1-608-258-3400.

Application for Accelerated Death Benefit -

☐ **Employee** ☐ **Spouse**

Employer: Has the employee assigned their benefits to another person or entity? ☐ Yes ☐ No

Note: If yes, ***STOP*** here and inform the employee that an ADB is not available unless the Assignee consents to review and payment of the Accelerated Death Benefit to the claimant.

Plan Sponsor: Please complete **Section A** and forward the package to the employee. When the employee returns the information please forward it along with the claimant's prior two years enrollment forms to: **Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.**

Section A:

Employer Name and Address	Control-Suffix-Account 621126 - _____ - _____ Amount of Basic Insurance $ _____ (TRM1 or 2) Amount of Optional Insurance $ _____ (TRM3 or 4)

1. If insurance is based on earnings, basic rate of earnings on date last worked.
   $_____ per ☐ Hour ☐ Week ☐ Month ☐ Year

2. a. Effective Date of Employee's Insurance _____
   b. Effective Date of Spouse's Insurance _____

3. Are premiums still being paid on this employee? ☐ Yes ☐ No

4. Sex ☐ Male ☐ Female	5. Date Employed	6. Date Last Worked	7. Employee Certificate Number and Social Security Number

8. Was the employee required to submit evidence of insurability? ☐ Yes ☐ No
   Note: If yes, date evidence submitted:

9. What is the Disability Provision? ☐ Premium Waiver ☐ PTD ☐ DBO-AID ☐ DBO
   Our Premium Waiver department will contact you regarding your eligibility.

10. Has employee submitted a claim for permanent total disability? ☐ Yes ☐ No
    Note: If yes, date claim submitted:

11. Maximum allowable ADB
    Basic $_____ and/or _____%
    Optional $_____ and/or _____%

_____ _____
Date Signature of Employer's Benefit Representative Telephone

Employee: Please complete **Section B**. Return this application together with the Insurer's Copy of the "Authorization to Release Information" form to your employer. Your medical records can be sent directly to the Aetna at the address above.

Section B: ******* PLEASE PRINT OR TYPE THE INFORMATION BELOW *******

Employee's Name & Address	Date of Birth	Social Security Number
Spouse's Name & Address (if applicable)	Date of Birth	Social Security Number

Amount of accelerated death benefit requested: Basic $_____ and/or _____%
Optional $_____ and/or _____%

Note: The amount you request cannot exceed the amount shown in box 11.

Warning: Any person who knowingly and with intent to injure, defraud or deceive 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. **Attention California Residents:** For your protection, California law requires notice of the following to appear on this form. 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. **Attention Colorado Residents:** 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. **Attention Florida and Virginia Residents:** Any person who knowingly and with intent to 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. **Attention Kentucky, Ohio and Pennsylvania Residents:** 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. **Attention Louisiana Residents:** 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. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Attention New York Residents:** 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

_____ _____ _____
Date Signature of Employee Telephone

Request for Medical Documentation

Date

Group Policy No: _____ Employer: _____

Employee Name: _____ Employee's SSN: _____

Spouse Name(if applicable): _____ Spouse's SSN: _____

Dear Physician:

I have elected to claim part of my group life insurance benefits to which I may be entitled if my life expectancy is less than _____ months (specified under the Plan).

I must provide the following medical documentation to the Insurance Company for evaluation of benefit eligibility:

- An Attending Physician's Statement.
- A narrative summary describing the diagnosis, prognosis, modality of treatment, and clinical response to treatment,
- Clinical records for the terminal disease.
- An assessment of mental competency.
- Names, addresses, and phone numbers of other treating physicians, if applicable.
- Your assessment on the medical probability that my life expectancy will be (_____) months or less. Please provide the medical rationale in support of your opinion.
- If it is medically probable that my life expectancy will exceed (_____) please provide an opinion on my projected life expectancy. If you are unable to establish a projected life expectancy at this time, please contact me if this situation changes.

Attached is a signed Release authorizing you to submit the requested information to the Insurance Company, for their review. **Please forward the records, with a copy of this letter to assure proper identification, directly to:**
Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.
Thank you for your prompt assistance in this matter.

_____ _____
Signature of employee Date

_____ _____
Signature of spouse (if applicable) Date

Instructions: Sign and date this Request for Medical Documentation. Send this request and the Physician's copy of the Authorization to Release Medical Information form to your physician.

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to: Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____

Date Signature of employee, or his/her Authorized Representative*

_____ _____

Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Physician's Copy

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

Primary Care Physician Name: _____

Address: _____

Telephone #: _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to: Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____

Date Signature of employee, or his/her Authorized Representative*

_____ _____

Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Insurance Company Copy

Authorization To Obtain Information For Insurance Benefits

I _____, _____
(print name of beneficiary), *(relationship to insured/deceased)*
hereby authorize the release of records on _____ from any
(print name of insured/deceased)
physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to: **Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.**

I understand the information obtained by use of this Authorization will be used for the purpose of evaluating and administering the claim for insurance benefits on

_____ SSN _____ - _____ - _____ .
(print claimant name)

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of Claimant/Legal Representative : _____ Date: _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant: Sign and date both copies of this Authorization. Send the Physician's copy with the Authorization to Obtain Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Benefits.

Physician's Copy

Authorization To Obtain Information For Insurance Benefits

I _____, _____
(print name of beneficiary), *(relationship to insured/deceased)*
hereby authorize the release of records on _____ from any
(print name of insured/deceased)
physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to: **Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.**

I understand the information obtained by use of this Authorization will be used for the purpose of evaluating and administering the claim for insurance benefits on

_____ SSN _____ - _____ - _____ .
(print claimant name)

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of Claimant/Legal Representative : _____ Date: _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant: Sign and date both copies of this Authorization. Send the Physician's copy with the Authorization to Obtain Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Benefits.

Insurance Company Copy

Attending Physician's Statement
Accelerated Death Benefit Request

Send this form to:
Wisconsin Manufacturers & Commerce
P.O. Box 352
Madison, WI 53701-0352.

- The patient is responsible for completion of this form without expense to the company.
- You may use the Remarks section on the reverse side if you need more room to respond. Complete this form in Full.

Your patient has requested early release of a portion of his/her life insurance under the accelerated death benefit provision of the employer plan named below. In order to determine eligibility for this benefit and process this request, the following information is necessary.

Patient Information

Name	Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)

Address (include No. Street, Town, State, Zip Code) ☐ Address is new

Employer Information

Name of Employee	Name of Employer	Control Number

1. Diagnosis and History

Diagnosis (including any complications)

IDC diagnostic code (**mandatory**)	Date of last examination (MM/DD/YYYY)

Subjective symptoms

Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
Clinical findings:

Diagnostic Studies and Results:

Are there any other illnesses, opportunistic infections, medical conditions, complications or significant findings affecting present condition? ☐ No ☐ Yes If "yes," please describe:

Height	Weight	Are there any weight loss patterns? ☐ No ☐ Yes If "yes," please describe:

Date symptoms first appeared or accident happened (MM/DD/YYYY)	What is the current stage of the insured's illness?

Has patient ever had same or similar condition? ☐ No ☐ Yes If "Yes," state when and describe:	Date(s) of any recurrences (MM/DD/YYYY)	Date patient ceased work because of disability MM/DD/YYYY)

2. Nature of Treatment

Type and dates of treatment:

Prescribed Medications:

Surgical procedures and dates:

2. Nature of Treatment (cont.)

How has patient responded to treatment?

Has Patient been hospital confined? ☐ No ☐ Yes If "yes," give name and address of hospital:

Confined from _____ Through _____

3. Progress and Limitations

Patient is: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

What is the patient's Activities of Daily Living status:

Performance Status Scale:
Karonfsky _____%

Or ECOG (Zubrod) _____

What restrictions are placed on the patient?

4. Cardiac (if applicable)

Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete

5. Mental Status

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ No ☐ Yes

6. Prognosis

What is the patient's Prognosis?

☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other

On what date did you diagnose the patient as terminally ill? (MM/DD/YYYY)

Life Expectancy: Is the insured expected to die within the next 6, 9, 12, 18 or 24 months? ☐ No ☐ Yes

If "Yes," how many months until the expected date of death? _____ months

7. Treating Physicians

Names and addresses of other treating physicians:

8. Remarks

Attending Physician's Name (print)	Specialty	Degree

Address (No., Street, City, State, Zip Code)	Telephone Number

Signature	Date

Warning: Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. 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.

Attention Colorado Residents: 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.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to 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.

Attention Kentucky, Ohio and Pennsylvania Residents: 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.

Attention Louisiana Residents: 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.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Aetna

Sample Letter to Employee

<Date>

<Name>
<Address>
<City, State, Zip Code>

RE: Employee: <Employee's Name>
Plan Sponsor: <Plan Sponsor>
Control Number: <Control Number>

Dear <Name>:

We understand that you have requested to apply for an Accelerated Death Benefit. In order for Aetna Life Insurance Company, hereafter referred to as Aetna, to determine if you qualify for this benefit, please follow these instructions:

First, make sure you have received the items listed below:

- One Application for Accelerated Death Benefit
- One Request for Medical Records letter
- Two copies of the Authorization to Release Information forms
- One Authorization to Obtain Information
- One Attending Physician's Statement
- One Accelerated Death Benefit Assignee Consent form to be completed when an Absolute Assignment has been executed
- One Accelerated Death Benefit Disclosure Statement

After you have read this letter:

- Read the Disclosure Statement and keep it for your records.
- Complete and sign the employee section of the Application for Accelerated Death Benefit form. Sign and date both copies of the Authorization to Release Information forms and the Authorization to Obtain Information form. Send one copy of each completed form to the Aetna.
- Sign the Request for Medical Records letter and forward it along with the Authorization to Release Information form and the Attending Physician's Statement form to your physician. The Attending Physician's Statement and medical records must be returned to Aetna.
- If you completed an Absolute Assignment, send the Assignee Consent form to your Assignee for completion. The completed form must be returned to Aetna.

The information to be provided to Aetna may be mailed to:

Wisconsin Manufacturers & Commerce
P.O. Box 352
Madison, WI 53701-0352.

Please be certain that either you or your physician provide Aetna with the necessary medical records for our use in determining your eligibility for this benefit.

In order to avoid delays when responding to this letter, please include the name and Social Security Number for the Insured or deceased in any correspondence.

If you need assistance or have any questions, regarding your claim, please contact Aetna's Customer Service Unit at 1-800-523-5065.

Sincerely,

<Name and Title>
Aetna Life Insurance Company

cc: <Plan Sponsor's Name>

Aetna Life Insurance Company
Accelerated Death Benefit Disclosure Statement

(Herein after referred to as ADB)

Any ADB paid by Aetna Life Insurance Company in accordance with your request for payment under the terms of your Certificate and the Group Policy will be subject to the following:

1. Upon payment of an ADB, the Scheduled Amount of Life Insurance in force prior to the ADB payment will be reduced by the amount of the ADB payment, subject to the terms and conditions of the Group Policy.

   EXAMPLE
   (a) Amount of Life Insurance prior to payment of ADB $100,000.00
   (b) ADB approved and paid (at 50% of (a)) ..... $ 50,000.00
   (c) Amount of Life Insurance remaining ..... $ 50,000.00

2. The Scheduled Amount of Life Insurance remaining after payment of the ADB may later be subject to further reduction or termination in accordance with the provisions contained in the Group Policy. Please contact the benefit representative of the Employer's Plan for additional information.

3. When the Group Policy terminates with respect to your Employer, an ADB will not be available, and a request for such benefit will not be approved.

4. The amount that may be requested as an ADB is a specified percentage of the Scheduled Amount of Life Insurance, as described in your Certificate, subject to the maximum allowed by your Employer's Plan

5. Payment of an ADB may adversely affect eligibility for Medicaid or other governmental benefits or entitlements.

6. The Group Policy is not a long term care policy, as may be defined in any applicable section of the laws or regulations of the jurisdiction in which the Employer's Plan was issued.

7. There is no separate charge for the ADB coverage provided under the Group Policy. However, premiums may be increased in order to recover the additional costs that will result from payment of ADB under the Group Policy.

8. Accelerated benefit payments from this policy may qualify for special tax status, if, according to federal definitions, the insured qualifies as terminally ill. However, if the accelerated benefit is based on “medical conditions” and not terminal illness as defined in the federal tax code, the benefits may be taxable. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product. **Payment of the accelerated death benefit will generate a form 1099**.

IMPORTANT: KEEP THIS DISCLOSURE STATEMENT FOR YOUR RECORDS.

Accelerated Death Benefit
Assignee Consent Form

I/We _____ _____

State that I/We are of legal age and the assignee(s) of the group life insurance policy benefits payable on the life

of _____, _____ who is insured under
Insured's Name *Social Security Number*

Group policy number _____ issued by Aetna Life Insurance Company (Aetna) to

_____. I/We hereby consent and request Aetna to review and
Plan Sponsor Name

Pay the accelerated Death Benefit to _____.
Insured's Name

Sign Here _____

_____

_____

State/Providence of _____

County of _____

On this _____ day of _____, 20_____, personally

Appeared before me at _____

State/Providence of _____, the above named

_____
(Insert here the names of all persons making this statement)

and made oath that the statements and answers above made and subscribed are true and full.

Notary Public _____

My Commission Expires _____

Questions and Answer Sheet

This sheet is intended to provide information on commonly asked question as by Employers and employees.

What is involved in the Claim Process?

A claim kit will be provided to you by your sales or service representative that will include:

- An Application for Accelerated Death benefit. Complete the Employer section of the application and forward it with the remainder of the forms to the employee.

- The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" and return it with the "Authorization to Release Information" to their employer.

- The employer will send the "Application", "Authorization to Release Information" along with the prior two years enroll forms to: Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352.

- A Disclosure Statement

  (a) Standard Option. This form applies when the employee does not incur an interest charge that is deducted from his/her benefit. This document provides the claimant with basic information on how the ADB benefit will impact the life benefit.

  (b) Discount Option. This form applies when there is an interest charge deducted from the ADB payment. The interest charge deducted is equal to the current rate of a three-month United States Treasury bill in effect on the date of payment and is calculated for the period of the life expectancy period as stated in the contract.

- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization To Release Information" and send them to their physician(s) along with the "Attending Physician's Statement".

- The medical documentation should be sent to: Wisconsin Manufacturers & Commerce, P.O. Box 352, Madison, WI 53701-0352 along with a copy of the "Request for Medical Documentation letter".

ADB Forms (GC-1459 & GC 1459-1) are available on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

For State of Connecticut residents only – the interest charge is the Aetna standard rate not to exceed 8%.

What happens when Aetna receives the completed claim form and medical records?

- The entire claim file will be reviewed. Aetna may require an independent medical examination at Aetna's expense. (not applicable for State of Connecticut residents)

- When a claim is approved, the payment will be forwarded within a week either directly to the Claimant or to the Employer for distribution to the Claimant.

- When a claim is denied, we will inform the Claimant that benefits are not payable at the present time and that for a re-evaluation of his/her claim, he/she should let us know immediately when there is a change in his/her medical status.

What is the responsibility of the Claimant?

He/she must provide his/her Physician(s) with the model letter, Attending Physician's Statement and a medical release form. The Clamant is then responsible to follow up with his/her Physician and make sure the Physician provides the medical information required by Aetna in order to evaluate his/her claim.

If the claim is not approved, can the Claimant appeal the decision?

Yes, the Claimant can always appeal the claim decision. However, his/her Physician must provide up to date medical documentation that the life expectancy is within the timeframe of the policy. The Physician may also want to discuss this issue with our medical professionals.

What is the tax status of an ADB payment?

The ADB benefit received may be subject to income tax. At the end of the year Aetna reports all ADB payments to the IRS and generates a 1099 that is mailed to each Clamant. We must provide the IRS with the amount that was paid and confirm that the insured's Physician certified that the claimant is terminally ill and will die within 24 months. The employee should consult with his/her tax advisor or the IRS for additional information on the tax implications of these benefits on his/her own personal income.

What happens when the claimant dies?

The Employer should submit a proof of Death form with the death certificate and all pertinent beneficiary cards.

Where should other questions regarding this benefit be directed?

Contact your Analyst at: 1-(800) 523-5065.

Claim Kits

ADB Claim Kits (GC-1459 & GC-1459-1) are located on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

The claim kit includes the following letters and forms which are located on the Life Claim Service Center website under forms and letters.

Forms:

Instruction Page

1. Employee/Spouse Claim Application Form
2. Request for Medical Documentation
3. Authorization – Physician's Copy
4. Authorization – Insurance Company Copy
5. Disclosure Statement – Non Discount (Standard)
6. Disclosure Statement – Discount Option
7. Attending Physician's Statement
8. Accelerated Death Benefit Assignee Consent Form

Letters

1. Letter to Employee
2. Letter to Employer

Additional Documents

Located in the Life Claim website under ADB Letters:

1. EE – D – App.doc – Approval letter to employee non-discounted (standard option)
2. EE – App.doc – Approval letter to employee discount option
3. EE – Approval letter to employee – discount option for State of CT resident.doc