

GROUP ACCELERATED DEATH BENEFIT CLAIM FORM

By furnishing this blank and investigating the claim the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Policy.

At the request of the insured employee, member or legal representative, THIS CLAIM FORM COMPLETED AND SIGNED BY EMPLOYER OR PLAN ADMINISTRATOR AND THE ATTENDING PHYSICIAN'S STATEMENT should be sent to:

FORT DEARBORN LIFE INSURANCE COMPANY
300 East Randolph Street, Chicago, Illinois 60601
1-800-348-4511

INSURED INFORMATION

Name of Insured Address-Street City State Social Security Number

Group Number Certificate Number Ins. Class No. Basic Earnings Date of Birth

Amount of Life Insurance Date Employed Date Last Worked Full Time

If Group Policy Issued to a Union or Trust Plan, Please Answer the Following:

Date Insured Became a Member

ALL POLICYHOLDERS should attach assignment forms, original enrollment card and all Beneficiary Change Forms.

POLICYHOLDER INFORMATION

Do you recommend payment of Claim? Yes No Remarks—

Policyholder Address

Date By Title Phone Number

ACCELERATION INFORMATION

Amount Elected to Accelerate

50% Other % up to a maximum of 50% (up to a maximum of 25% in Connecticut) or \$125,000, whichever is less.

I have read and signed the Disclosure Notice, which is attached as part of my request for Accelerated Death Benefits.

Signature of Insured/Legal Representative

Date

Authorization request to be completed by Insured/Legal Representative:

I hereby request and authorize any hospital, physician, or other person who has attended or examined me to furnish to Fort Dearborn Life Insurance Company of Chicago, Illinois, or its representative, any and all information concerning any illness or injury I may have suffered, medical history, consultations, prescriptions, or treatments including X-ray plates and copies of all hospital or medical records, that same may be included as a part of the proofs of loss submitted by me to the Company. Fort Dearborn Life Insurance may also release information contained in its files to its reinsurers including the information obtained hereby. A copy of this authorization shall be considered as effective and valid as the original.

Dated _____, 19____
Month Day Year

Witness

Signature of Insured

Address

Address

ATTENDING PHYSICIAN'S STATEMENT

Patient Name:

Date of Birth:

1. Diagnosis —

2. History —

When did this illness/injury occur?

Is there a prior history of this condition?

Is this condition due to patient's employment? (If so, explain briefly)

3. Present condition —

What symptoms are now present?

Have you obtained objective findings (lab, x-ray) outside the normal limits? If so, explain briefly or attach report.

A "Terminally Ill Insured" is defined as an insured, age 64 or less, who is expected to die within 9 months, due to a medical condition. Does your patient fall within this definition?

Date Signature of Attending Physician Degree State Licensing # Telephone Number

Street Address City/Town State/Province Zip code