Clear Form
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AMERICAN NATIONAL®

Standard Life & Accident Insurance Company

Accelerated Death Benefit Claimant Statement

PO BOX 10546, SPRINGFIELD, MISSOURI 65808-0546 (888) 350-1488

NOTE: **TERMINAL ILLNESS** is an uncorrectable medical condition which, with reasonable medical certainty, will result in the death of the Insured in less than 12 months from the date of the Attending Physician's Statement.

Certificate Number: _____

1. Claimant

Name: Last	First	M.I.	Date of Birth

2. Owner

Name: Last	First	M.I.

Daytime telephone

Address	City	St	ZIP

1. What is the nature of your illness? _____
2. Date you first noticed symptoms? _____
3. When were you first treated for this condition? _____
4. When was the diagnosis made? _____
5. Names and addresses of all physicians, hospitals, and/or institutions who have treated you for this condition (if additional space is needed, please use other side of this page):

Name	Address	First Visit

IMPORTANT NOTICES

The undersigned agrees to furnish, without expense to the Company, written statements by any physician who may have attended or treated the insured and such other information applicable to this request for payment as may be called for by the Company, it being understood that all such statements and information shall form a part of these proofs. It is further understood and agreed that the Company does not waive any defenses available to it by furnishing these forms for proof of loss.

AUTHORIZATION

I hereby authorize my physician to release any information acquired in the course of my examination or treatment to Standard Life and Accident Insurance Company and its subsidiaries to view and obtain a copy of my records pertaining to my employment, medical treatment, medical history, and prescriptions. I understand that the information I am authorizing to be released may include:

1. AIDS/HIV test results, diagnosis, treatment, and related information.
2. Drug screen results and information about drug or alcohol use and treatment.
3. Mental health information.

I further understand that this authorization is valid for two years from the date executed below. I also understand that I may revoke this authorization at any time during the two year period by notifying the Claims Department in writing at the address shown at the top of this form. The information obtained by this authorization may be disclosed to reinsurance companies, if policy is reinsured, to any agency employed by the Company and to any party which the Company is required by law or subpoena to disclose.

You may honor a photographic copy of this authorization.

The statements made herein are complete and true to the best of my knowledge and belief.

Signature of Owner _____ Date _____