Cotton States INSURANCE®

COTTON STATES LIFE AND HEALTH INSURANCE COMPANY
244 Perimeter Center Parkway N.E. Atlanta, Georgia 30346
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ATTENDING PHYSICIAN'S STATEMENT FOR ACCELERATED BENEFIT

DATE:_____

TO:_____M.D.

_____

_____

Patient's Name:_____

Patient's Social Security No:_____

Patient's Date of Birth:_____

Dear Dr. _____:

We have received a request for the advancement of a portion of the life insurance benefit on your patient. This is a benefit provided by Cotton States Life and Health Insurance Company's Accelerated Benefit Option Rider. The attached authorization has been given by your patient for the release of their medical records. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. What is the diagnosis of the patient's medical condition?_____

2. What date did you first treat the patient for this medical condition?_____

3. Is the patient's medical condition the result of an attempt to commit suicide? ____Yes ____No

4. Is the patient disabled? ____Yes ____No (If 'Yes', complete sections A and B.)

   A. Date of Disability _____ B. Degree of Disability: ____Partial ____Total

5. What is the patient's expected life span?_____

6. Is the patient presently confined to a Nursing Home? ____Yes ____No

   If 'Yes', please complete the following information.

   A. NAME OF NURSING HOME DATE FIRST CONFINED

   _____ _____

   B. Has the patient been confined to the Nursing Home for **all** of the preceding six months? ____Yes ____No

   C. Do you expect the patient to remain in a Nursing Home for the remainder of their life? ____Yes ____No

If there is a fee for the completion of this form, please submit a bill.

_____ _____

Signature of Physician Date Social Security/IRS Number

LC-38 (Rev 4/92)