



151 Farmington Avenue  
Hartford, CT 06156  
Telephone Number: 1-800-523-5065

# Accelerated Death Benefit (Discount Option)

## Aetna Life Insurance Company

### INSTRUCTION PAGE

#### Enclosed please find:

- A Request for Accelerated Death Benefit
- A Request for Medical Documentation letter
- Two Authorizations to Release Information
- An Authorization to Obtain Information
- An Authorization for the Aetna Care Advocate
- 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 "Request for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.
2. For employees and spouses of an employee who are eligible for an Accelerated Death Benefit, Aetna provides the member with valuable and direct access to a licensed social worker who can assist them with the delivery of their life, health care and emotional needs. Our care advocate is sensitive to the physical, emotional, spiritual and culturally diverse needs of individuals and families who are facing tough decisions associated with a life-limiting illness. Our dedicated care advocate is available to the member during normal business hours and is available to assist the member with any questions they may have with completing the enclosed forms and may be reached by calling:  
1-800-238-5120.
3. If coverage is contributory, forward the current and prior 2 years enrollment forms to the Aetna at the address or fax number shown below.

#### **Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
P.O. Box 14549  
Lexington, KY 40512-4549  
Fax Number: 1-800-238-6239

#### **Overnight Address:**

ACS, Inc.  
Attn: Life Claims  
101 Yorkshire Boulevard  
Lexington, KY 40509

4. Forward the Accelerated Death Benefit claim kit to the employee.
5. The employee is to complete the Employee section of the "Request for Accelerated Death Benefit" and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" form to the Aetna. To enable assistance from the care advocate, the insured is to complete, sign and date the Authorization for the Aetna Care Advocate and return it to the Aetna using the fax number or Address shown in step 3.
6. 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 the Aetna using the fax number or Address shown in step 3.
7. 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.
8. The medical documentation can be mailed or faxed to the Aetna at the fax number or address shown in step 3.



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# Request for Accelerated Death Benefit

**Employee:** Is this claim for:  You  Spouse

Have you assigned your benefits to another person or entity?  Yes  No

If yes, please provide the following information:

Assignee Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

The completed form must be mailed or faxed to the fax number or address shown below.

**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 current and prior two years enrollment forms to:

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
 Attn: Life Claims  
 101 Yorkshire Boulevard  
 Lexington, KY 40509

**Section A:**

|   |  |  |  |
|---|--|--|--|
| Employer Name and Address   |  | Control-Suffix-Account-Plan _____ - _____ - _____        |  |
|   |  | Control-Suffix-Account-Plan _____ - _____ - _____        |  |
|   |  | Amount of Basic Insurance \$ _____                       |  |
|   |  | Amount of Optional Insurance \$ _____                    |  |
| 1. If insurance is based on earnings, basic rate of earnings on date last worked.<br>\$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year                            |  |  |  |
| 2. a. Effective Date of Employee's Insurance _____  |  | 3. Are premiums still being paid on this employee?       |  |
| b. Effective Date of Spouse's Insurance _____   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 4. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female   | 5. Date Employed _____                         | 6. Date Last Worked _____                                | 7. Employee Certificate Number or Social Security Number _____ |
| 8. Was the employee required to submit evidence of insurability? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Note:</b> If Yes, date evidence submitted: _____  |  |  |  |
| 9. What is the Disability Provision? <input type="checkbox"/> Premium Waiver <input type="checkbox"/> PTD <input type="checkbox"/> DBO-AID <input type="checkbox"/> DBO<br>Our Premium Waiver department will contact you regarding your eligibility. |  |  |  |
| 10. Has employee submitted a claim for permanent total disability?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>Note:</b> If yes, date claim submitted: _____   |  |  |  |
| 11. Maximum allowable ADB<br>Basic \$ _____ and/or _____ %<br>Optional \$ _____ and/or _____ %  |  |  |  |
| _____   | _____  | _____  | _____  |
| Date  | Signature of Employer's Benefit Representative | Telephone Number   |  |

**Employee:** Please complete **Section B**. Return this form 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 fax number or address shown above.

Please check one of the following:

I have been diagnosed with a terminally ill condition.

I have been diagnosed with a covered medical condition that is expected to result in a drastically limited life span.

|                 |                        |
|-----------------|------------------------|
| Claimant's Name | Social Security Number |
|-----------------|------------------------|

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

|   |                  |                          |                  |
|---|------------------|--------------------------|------------------|
| Employee's Name & Address               | Date of Birth    | Social Security Number   | Telephone Number |
| Spouse's Name & Address (if applicable) | Date of Birth    | Social Security Number   | Telephone Number |
| Caregiver Name & Address                | Telephone Number | Relationship to Claimant |                  |

Is the claimant currently residing at home?  
 Yes  No If no, please provide the name, address and telephone number of the current residence.

Do you have medical coverage through Aetna?  Yes  No

If yes, please provide your ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Member Services Telephone Number \_\_\_\_\_ (This information is found on your Aetna ID card).

If no, please provide the following:

Name and Address of your Medical insurer \_\_\_\_\_

Group/Plan Number \_\_\_\_\_ Member ID Number \_\_\_\_\_ Insurer's Telephone 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.

For policy's issued in New York or claimant's residing in New York: Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policy owners or certificate holders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Further, receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policy owners or certificate holders should seek assistance from a qualified tax advisor. In addition, no health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

This request for accelerated death benefits is voluntary and without coercion on the part of any third party.

Within 5 days of receipt of this completed Request form Aetna will provide an acknowledgement letter to the policy owner or certificate holder containing the information specified in New York Insurance Law §3230 (d). New York Insurance Law §3230 (c) prohibits Aetna from paying accelerated death benefits for a period of 14 days from the date on which the information specified in New York Insurance Law §3230 (d) is transmitted in writing to the policy owner or certificate holder. The completed request form must be signed and dated and received by Aetna within 30 days from the date shown on the acknowledgement letter and request form.

Print name of policy owner or certificate holder \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

|                 |                        |
|-----------------|------------------------|
| Claimant's Name | Social Security Number |
|-----------------|------------------------|

**Section C:**

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 Arkansas, Louisiana and West Virginia 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 California, 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 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 Residents:** 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.

**Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Kentucky 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 may subject such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information 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.

**Attention North Carolina Residents:** 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 may be a crime and subjects such person to criminal and civil penalties.

**Attention Oklahoma Residents: 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.

**Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Attention Vermont Residents:** 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 may be a crime and may subject such person to criminal and civil penalties.

**Attention Virginia Residents:** 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 act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Washington Residents:** 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.

|      |                       |                  |
|------|-----------------------|------------------|
| Date | Signature of Employee | Telephone Number |
|------|-----------------------|------------------|



151 Farmington Avenue  
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# 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 1) my life expectancy is less than \_\_\_\_\_ months (specified under the Plan) or 2) I am diagnosed with a medical condition that is expected to result in a drastically limited life span. I am requesting your assistance to obtain benefit described in 1  or 2  (check one).

I must provide the following medical documentation to Aetna Life Insurance Company ("Aetna") for evaluation of benefit eligibility:

- A fully completed 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 your patient's mental competency
- Names, addresses and phone numbers of other treating physicians, if applicable
- Please provide the medical rationale in support of your opinion.

1) To fulfill a request for an Accelerated Death Benefit based on life expectancy:

- Your assessment on the medical probability that my life expectancy will be (\_\_\_\_\_) months or less.
- 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.

2) To fulfill a request for an Accelerated Death Benefit based on medical condition:

- Your assessment on the medical probability that my life expectancy will be drastically reduced because I have been diagnosed with one or more of the following conditions:
  - Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
  - End stage heart, kidney, liver and/or pancreatic organ failure and the person is not a transplant candidate
  - A medical condition requiring artificial life support, without which the person would die
  - A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a Hospital or Skilled Nursing Facility
  - Acquired Immune Deficiency Syndrome

Attached is a signed Release authorizing you to submit the requested information to Aetna. Please forward the records, with a copy of this letter to assure proper identification, directly to the Insurance Company.

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
 Attn: Life Claims  
 101 Yorkshire Boulevard  
 Lexington, KY 40509

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, ARC, Mental Illness and Substance Abuse Information

Employee's Name \_\_\_\_\_

Employee's SSN \_\_\_\_\_

Spouse's Name (if applicable) \_\_\_\_\_

Spouse's SSN \_\_\_\_\_

Employer \_\_\_\_\_

To all Physicians:

I hereby authorize you to provide Aetna Life Insurance Company ("Aetna") information concerning the health condition of the person for whom information is being requested. HIV, AIDS, ARC, Mental Illness and Substance Abuse tests results may be released pursuant to this release. This information will be used solely 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 the contract under which a request for an Accelerated Death Benefit has been submitted.

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
P.O. Box 14549  
Lexington, KY 40512-4549  
Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
Attn: Life Claims  
101 Yorkshire Boulevard  
Lexington, KY 40509

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 Request for Accelerated Death Benefits.

**Physician's Copy**

## Authorization To Release Information Including Release of HIV, AIDS, ARC, Mental Illness and Substance Abuse 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:

I hereby authorize you to provide Aetna Life Insurance Company information ("Aetna") concerning the health condition of the person for whom information is being requested. HIV, AIDS, ARC, Mental Illness and Substance Abuse tests results may be released pursuant to this release. This information will be used solely 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 the contract under which a request for an Accelerated Death Benefit has been submitted.

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
P.O. Box 14549  
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**Overnight Address:**

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101 Yorkshire Boulevard  
Lexington, KY 40509

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 Request for Accelerated Death Benefits.

**Insurance Company Copy**



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## Authorization To Obtain Information For Insurance Benefits

I \_\_\_\_\_ (print name)

Relationship to insured (please check one)

- Self  
 Spouse  
 Parent  
 Personal Representative (attach copy of appointment by court)  
 Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)  
 Other \_\_\_\_\_ hereby authorize the release of records for \_\_\_\_\_ SSN \_\_\_\_\_ (print name)

from any 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 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:**

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
 Attn: Life Claims  
 101 Yorkshire Boulevard  
 Lexington, KY 40509

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim on the insured and for the administration of any other benefit or service the claimant may be eligible for if the Request for the Accelerated Death Benefit is approved.

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 re-disclosed 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 \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

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/Legal Representative:** Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Request for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

### Physician's Copy



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## Authorization To Obtain Information For Insurance Benefits

\_\_\_\_\_ (print name)

Relationship to insured (please check one)

- Self
- Spouse
- Parent
- Personal Representative (attach copy of appointment by court)
- Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)

Other \_\_\_\_\_ hereby authorize the release of records for \_\_\_\_\_ SSN \_\_\_\_\_

(print name)

from any 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 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:**

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
 Attn: Life Claims  
 101 Yorkshire Boulevard  
 Lexington, KY 40509

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim on the insured and for the administration of any other benefit or service the claimant may be eligible for if the Request for the Accelerated Death Benefit is approved.

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 re-disclosed 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 \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

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/Legal Representative:** Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Request for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

### Insurance Company Copy

**Authorization for the Aetna Care Advocate to Release Information and Collaborate  
with various organizations for the benefit of the Insured  
(This Authorization is Voluntary for the Insured)**

I \_\_\_\_\_  
(print name)

Relationship to Insured (please check one)

- Self  
 Spouse  
 Parent  
 Personal Representative (attach copy of appointment by court)  
 Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)  
 Other \_\_\_\_\_

hereby authorize the Aetna Care Advocate to discuss the medical condition of the insured including the release of information on HIV, AIDS, ARC, mental illness and substance abuse with members of the medical team or other providers of services such as other insurance carriers to identify additional resources that may be available to assist the insured,

\_\_\_\_\_ such as:

(Name of insured)

- Employee assistance programs
- Social service agencies
- Community agencies
- National organizations
- Hospice agencies
- Volunteering agencies
- Life planning service agencies
- Financial planning agencies
- Providers of medical equipment and supplies

I understand the information obtained by use of this Authorization will be used for the purpose of evaluating and administering the benefits available under this plan.

This authorization is valid for the term of the claim that 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 re-disclosed 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 \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Insured's SSN \_\_\_\_\_ and Telephone Number \_\_\_\_\_

Telephone Number of claimant's legal representative \_\_\_\_\_

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/Legal Representative: Sign and date this Authorization. Mail or fax the Authorization to Obtain Information for Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Application for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.**



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 Hartford, CT 06156  
 Telephone Number: 1-800-523-5065

## Attending Physician's Statement Accelerated Death Benefit Request

Send this form to:  
 Aetna Life Insurance Company  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Telephone: 1-800-523-5065  
 Fax: 1-800-238-6239

- 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 to process this request, the following information is necessary.**

|                             |   |                          |                        |                         |
|-----------------------------|---|--------------------------|------------------------|-------------------------|
| <b>Patient Information</b>  | Name  | Relationship to Employee | Social Security Number | Birth date (MM/DD/YYYY) |
|                             | Address (include No. Street, Town, State, Zip Code) <input type="checkbox"/> Address is new |                          |                        |                         |
| <b>Employer Information</b> | Name of Employee  | Name of Employer         |                        | Control Number          |

**1. Diagnosis and History** Please check for a Diagnosis of:

Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)  
 End stage heart, kidney, liver and/or pancreatic organ failure and the person is not a transplant candidate  
 A medical condition requiring artificial life support, without which the person would die  
 A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a Hospital or Skilled Nursing Facility

If one of the above medical conditions has been diagnosed, is the medical condition expected to result in a drastically reduced life span?  Yes  No

Or Other Diagnosis (including any complications):

|   |   |   |
|---|---|---|
| IDC diagnostic code ( <b>mandatory</b> )  | Date of last examination (MM/DD/YYYY)   |   |
| Subjective symptoms   |   |   |
| Objective findings (including <b>current</b> X-rays, EKG's, laboratory data and any <b>clinical findings</b> )<br><b>Clinical findings:</b>   |   |   |
| <b>Diagnostic Studies and Results:</b>  |   |   |
| Are there any other illnesses, opportunistic infections, medical conditions, complications or significant findings affecting present condition?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "Yes," please describe: |   |   |
| Height  | Weight                                  | Are there any weight loss patterns?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>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 |

|  |  |   |
|--|--|---|
| <b>3. Nature of Treatment (cont.)</b>  | How has patient responded to treatment?  |   |
|  | Has Patient been hospital confined?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
|  | If "Yes," give name and address of hospital:<br>Confined from _____ Through _____  |   |
| <b>4. Progress and Limitations</b>     | Patient is<br><input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined<br><input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined  | What is the patient's Activities of Daily Living status?                  |
|  | Performance Status Scale<br>Karonfsky _____ %<br>Or ECOG (Zubrod) _____  | What restrictions are placed on the patient?                              |
| <b>5. Cardiac (if applicable)</b>      | Functional capacity limitation (American Heart Ass'n):<br><input type="checkbox"/> Class 1 (none) <input type="checkbox"/> Class 3 (marked)<br><input type="checkbox"/> Class 2 (slight) <input type="checkbox"/> Class 4 (complete)   |   |
| <b>6. Mental Status</b>                | Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| <b>7. Prognosis For Terminally Ill</b> | What is the patient's Prognosis?<br><input type="checkbox"/> Guarded <input type="checkbox"/> Good <input type="checkbox"/> Fair<br><input type="checkbox"/> Poor <input type="checkbox"/> Other                                       | On what date did you diagnose the patient as terminally ill? (MM/DD/YYYY) |
|  | <b>Life Expectancy:</b> Is the insured expected to die within the next 6, 9, 12, 18 or 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "Yes," how many months until the expected date of death? _____ months |   |
| <b>8. Treating Physicians</b>          | Names and addresses of other treating physicians   |   |
| <b>9. Remarks</b>                      |  |   |
|  | Attending Physician's Name (print)   | Specialty   |
|  | Address (No., Street, City, State, Zip Code)   |   |
|  | Telephone Number   |   |
|  | Signature  | Date  |

## 10. Misrepresentation

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 Arkansas, Louisiana and West Virginia 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 California, 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 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 Residents:** 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.

**Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Kentucky 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 may subject such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information 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.

**Attention North Carolina Residents:** 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 may be a crime and subjects such person to criminal and civil penalties.

**Attention Oklahoma Residents: 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.

**Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Attention Vermont Residents:** 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 may be a crime and may subject such person to criminal and civil penalties.

**Attention Virginia Residents:** 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 act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Washington Residents:** 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.



151 Farmington Avenue  
 Hartford, CT 06156  
 Telephone Number: 1-800-523-5065

**\*\*\*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 Request 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 Authorization for the Aetna Care Advocate
- 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 Request 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.

*Talking about the Accelerated Death Benefit can sometimes feel uncomfortable. For tips on talking about the Accelerated Death Benefit, to learn more about the benefit, or if you need assistance completing the Request for Accelerated Death Benefits form, contact Aetna's Care Advocate at 1-800-276-5120*

- For Aetna Care Advocate's assistance please complete, sign, date and return the Authorization for the Aetna Care Advocate
- 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.

**Claim Submission Address and Fax Number:**  
 Aetna Life Insurance Service Center  
 P.O. Box 14549  
 Lexington, KY 40512-4549  
 Fax Number: 1-800-238-6239

**Overnight Address:**  
 ACS, Inc.  
 Attn: Life Claims  
 101 Yorkshire Boulevard  
 Lexington, KY 40509

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.

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

(hereinafter 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 approved, before any reduction by the interest charge, subject to the terms and conditions of the Group Policy.

### EXAMPLE

|   |              |
|---|--------------|
| (a) Amount of Life Insurance prior to payment of ADB .....  | \$ 40,000.00 |
| (b) ADB approved (at 50% of (a)) .....                      | \$ 20,000.00 |
| (c) ADB paid (\$20,000 less \$350.88 interest charge) ..... | \$ 19,647.12 |
| (d) Amount of Life Insurance remaining .....                | \$ 20,000.00 |

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. Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policy owners or certificate holders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.
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. 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 \_\_\_\_\_  
(print name)

State that I am 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 hereby consent and request Aetna to  
*Plan Sponsor Name*

review and pay the Accelerated Death Benefit to \_\_\_\_\_.  
*Insured's Name*

\_\_\_\_\_  
*Print Assignee Name* *Signature* *Date*

\_\_\_\_\_  
*Assignee Address* *Telephone Number*

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 questions 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:

- A Request for Accelerated Death benefit. Complete the Employer section of the Request form and forward it with the remainder of the forms to the employee.
- The employee is to complete the Employee section of the “Request for Accelerated Death Benefit” and return it with the “Authorization to Release Information” to their employer.

The employer will send the “Request for Accelerated Death Benefit”, “Authorization to Release Information” along with the current and prior two years enrollment forms to:

**Claim Submission Address and Fax Number:**

Aetna Life Insurance Service Center  
P.O. Box 14549  
Lexington, KY 40512-4549  
Fax Number: 1-800-238-6239

**Overnight Address:**

ACS, Inc.  
Attn: Life Claims  
101 Yorkshire Boulevard  
Lexington, KY 40509

- 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 the address shown above along with a copy of the “Request for Medical Documentation letter”.

ADB Forms (GC-1591 & GC 1592) are available on the Forms Repository:

[http://aetnet.aetna.com/bts/pages/plan\\_sponsor/contracting\\_consulting/forms/all-forms.html](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 the claim, the claimant should let us know immediately when there is a change in medical condition.

## **What is the responsibility of the claimant?**

The claimant must provide the treating physician(s) with the model letter, Attending Physician's Statement and a medical release form. The claimant is then responsible to follow up with the treating physician(s) 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 appeal the claim decision. However, the treating physician must provide up to date medical documentation that 1) the life expectancy is within the timeframe of the policy or 2) the medical condition covered by the policy will result in a drastically reduced life span. 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 claimant. 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 submits a Proof of Death claim form with certified death certificate showing the cause and manner of death and all pertinent beneficiary cards.

Questions regarding this benefit may be directed to the Customer Service Unit at: **1-800-523-5065**.