

ATTENDING PHYSICIAN'S STATEMENT

Advance Payment Request

Name of Insured: _____

Address: _____

City: _____ Postal Code: _____

The above named Insured has requested an advance payment of his/her Life Insurance proceeds due to a terminal illness. In order to provide consideration to the Insured's request, we require the following:

Diagnosis: _____

Prognosis: _____

Life Expectancy: _____

In the space below, please provide a description of the Insured's medical condition, including any complications, and attach a copy of any recent test results.

I certify the above information to be true and correct.

Physician's Name

Phone Number

Address

Physician's Signature

Date