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Qualified Care Facility Verification Form

SECTION 1 - OWNER INFORMATION

Full Name:	
Contract Number:	Annuitant Name(if different than owner):
Date of Birth:	Social Security Number (last four digits):

SECTION 2 - PHYSICIAN INSTRUCTIONS

To the Physician: Your patient is requesting a withdrawal from his/her annuity contract under the Confinement Care Rider. To assist us in determining eligibility for these benefits, we require a statement from you. Please review and complete Sections 3 and 4 below. If the contract owner and annuitant listed above are not the same person, then your patient is the annuitant.

SECTION 3 - QUALIFIED STAY INFORMATION

Patient resides in one of the following qualified care facilities (check one):

❑ Skilled Nursing Facility – means a facility:
1. That provides skilled nursing care supervised by a licensed physician; and
2. Provides 24-hour-a-day nursing care by, or supervised by, an R.N.; and
3. Keeps a daily medical record of each patient.

❑ Intermediate Care Facility – means a facility:
1. That provides 24-hour-a-day nursing care by, or supervised by, an R.N. or an L.P.N.; and
2. Keeps a daily medical record of each patient.

❑ Hospital – means a facility:
1. That operates for the care and treatment of sick or injured persons as inpatients; and
2. Provides 24-hour-a-day nursing care by, or supervised by, an R.N.; and
3. Is supervised by a staff of licensed physicians; and
4. Has medical, diagnostic and major surgical capabilities or access to such capabilities.

❑ Hospice – means a facility:
1. That provides a formal program for a terminally ill patient whose life expectancy is less than six months, provided on an inpatient basis directed by a qualified physician; and
2. Is licensed, certified or registered as a hospice in accordance with state laws.

***Please Note: Qualified care facilities DO NOT include:
1. Drug or alcohol treatment facilities;
2. Homes for the aged or mentally ill, community living facilities, or places that primarily provide domiciliary, residency or retirement care; or
3. Places that are owned or operated by a member of the owner/annuitant's immediate family.

Date continuous stay began: _____ Date continuous stay ended: _____

SECTION 4 - PHYSICIAN'S CONFIRMATION

Under penalties of perjury, I certify that:
1. The above-listed contract owner or annuitant is my patient, and
2. The information provided in this statement is accurate.

Signature of Physician: _____ Date: _____

Facility/Care Center Name: _____

Facility Address & Phone Number: _____

ORIGINAL FORM NOT REQUIRED - FAXED COPIES ARE ACCEPTABLE