A photocopy of this authorization will be considered as effective and valid as the original.

Valid for one year from date signed.

To Be Completed by Physician

Attending Physician's Certification

Patient's name: □□□□□□□□□□□□□□□□
Patient's Social Security Number: □□□□□
Diagnosis: □□□□□□□□□□□□□□□□□□□□
ICD–9–CM Disease Code *: □□□□□□□□□
Description of present medical condition (please attach results of x-rays, E.K.G. or other tests): □□□□□□□□□□□□□□□□□□□□
Is the patient capable of handling his/her own affairs? □□□□□□□□□□□□□□□□□□□□
□ Yes□ □ No □
The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement? □□□□
□ Yes□ □ No
Attending Physician's name (please print): □
State in which you are licensed to practice:
Specialty: □□□□□□□□□□□□□□□□□□□□
Mailing address: □□□□□□□□□□□□□□□□
Telephone number: □□□□□□□□□□□□□□
Fax Number: □□□□□□□□□□□□□□□□□□
Signature: □□□□□□□□□□□□□□□□□□□□
Date: □□□□□□□□□□□□□□□□□□□□□□

* ICD–9–CM is an acronym for International Classification of Diseases, 9th revision, Clinical Modification.

To Be Completed by Personnel Office of Servicemember's Unit

(Complete this form only if the applicant for Accelerated Benefits is covered under SGLI.)

Branch of Service Statement

Servicemember's name: □□□□□□□□□□□□□□□□
Social Security Number: □□□□□□□□□□□□□□□□
Branch of Service: □□□□□□□□□□□□□□□□□□□□
Amount of SGLI coverage: $ □□□□□□□□
Monthly premium amount: $ □□□□□□□□
Name of person completing this form: □□□
Telephone Number: □□□□□□□□□□□□□□□□□□
Fax Number: □□□□□□□□□□□□□□□□□□
Title of person completing this form: □□□
Duty Station and address: □□□□□□□□□□□□□□□□□□□□
Signature of person completing this form: □
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