Life shield National home office # 800-580-7211

Min face $3500
Max face $30000
Ages 50-85

Note ages 81-85
automatic graded benefit.

This carrier has great rate however are tighter on underwriting. Cannot be on disability before age 65, no cancer ever, no insulin.

Filling Out Application

Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes.
Always make a duplicate copy of file ***BEFORE*** filling out application with client info
Retitle file with clients first and last name
Fill out yellow highlighted boxes with client info

Weight Table

HGT	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3	6'4	6'5
Min	88	90	93	95	98	101	104	106	110	113	117	120	125	129	133	136	140	143	148
Max	206	213	220	227	234	241	248	256	263	271	279	287	295	303	312	320	329	337	346

How to Quote with Cardinal Quoting App]

Underwriting Type: Full
Product Type: Level

LifeShield National Insurance Co.

Survivor Plan
Premium: $40.79/mo*
Face Value: $10,000.00
Annual Fee: $25.00

Health Assessment/ Phone Interview

None available — — — Submit and you will be notified within a few days

How to Submit App

Email applications to newbusinessapp@uflic.com

Do not submit quick reference page. Delete before emailing

Once submitted move pdf into your client file

log client into senior agent tools

LifeShield National Insurance Co.

Administrative Office: 815 W. Ash Ave., Duncan, Oklahoma 73533

Individual Whole Life Application - Survivor Life Application

(If applying for Joint Life, please complete both Applicant 1 and Applicant 2 information)
Please Print Clearly

APPLICANT 1	APPLICANT 2
Proposed Insured's Name: First Middle Last	Proposed Insured's Name: First Middle Last
Address City State Zip Code	Address City State Zip Code
Home Phone: ( ) Cell Phone: ( )	Home Phone: ( ) Cell Phone: ( )
Email Address:_____	Email Address:_____
Sex: ☐ M ☐ F Date of Birth / / Height: Weight:	Sex: ☐ M ☐ F Date of Birth / / Height: Weight:
Social Security Number - - State or Country of Birth: Occupation:	Social Security Number - - State or Country of Birth: Occupation:
_____ _% Primary Beneficiary 1 Relationship _____ % Primary Beneficiary 2 Relationship	_____ % Primary Beneficiary 1 Relationship _____ % Primary Beneficiary 2 Relationship
_____ % Contingent Beneficiary 1 Relationship _____ % Contingent Beneficiary 2 Relationship	_____ % Contingent Beneficiary 1 Relationship _____ % Contingent Beneficiary 2 Relationship
Do you have any existing life insurance or annuity contract(s) with the company or any other company? ☐ Yes ☐ No	Do you have any existing life insurance or annuity contract(s) with the company or any other company? ☐ Yes ☐ No
Do you intend to replace or change any existing life insurance or annuity contract: ☐ Yes ☐ No If "Yes," complete section below	Do you intend to replace or change any existing life insurance or annuity contract: ☐ Yes ☐ No If "Yes," complete section below
Existing Coverage Insurer's Name: Policy/Certificate Number: Termination Date: Benefit Amount:	Existing Coverage Insurer's Name: Policy/Certificate Number: Termination Date: Benefit Amount:
Within the past 12 months, have you used tobacco in any form (including Marijuana, Vapes, or E-cigs)? ☐ Yes ☐ No	Within the past 12 months, have you used tobacco in any form (including Marijuana, Vapes, or E-Cigs)? ☐ Yes ☐ No

If any question in Section A is answered "Yes", the proposed insured is not eligible for any coverage.

Section A	**Applicant 1**	**Applicant 2**
1. Is the Proposed Insured currently a resident of a nursing home or skilled nursing facility; a patient in a hospital or psychiatric facility; confined to a correctional facility, receiving or been advised by a member of the medical professional to receive skilled nursing care, hospice care, or home health care within the past 5 years?	☐ Yes ☐No	☐Yes ☐No
2. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for (including prescription medications) congestive heart failure, peripheral neuropathy, epilepsy, schizophrenia, ALS (Lou Gehrig's disease), or does the Proposed Insured have a cardiac defibrillator?	☐ Yes ☐No	☐Yes ☐No
3. Has the Proposed Insured ever been diagnosed by a member of the medical profession with an un-operated aneurysm?	☐ Yes ☐No	☐Yes ☐No
4. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for Alzheimer's disease or dementia or been prescribed Aricept, Cognex, Donepezil, Exelon, Razadyne, or Namenda?	☐ Yes ☐No	☐Yes ☐No
5. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐No	☐Yes ☐No
6. Does the Proposed Insured use a wheelchair, or does the Proposed Insured require assistance (from anyone) with Activities of Daily Living: bathing, dressing, eating, toileting, walking, moving about, getting in or out of bed or chairs or taking medication?	☐ Yes ☐No	☐Yes ☐No
7. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for internal cancer or melanoma?	☐ Yes ☐No	☐Yes ☐No
8. Has the Proposed Insured ever been diagnosed, treated for (including prescription medications), or advised to receive treatment by a member of the medical profession for Parkinson's disease, multiple sclerosis, lupus, liver failure, Hepatitis C, cirrhosis of the liver, or kidney disease requiring dialysis?	☐ Yes ☐No	☐Yes ☐No
9. Has the Proposed Insured ever had or been advised by a member of the medical profession to have an organ transplant or bone marrow transplant?	☐ Yes ☐No	☐Yes ☐No
10. Has the Proposed Insured been diagnosed or treated by a member of the medical profession for diabetes and use or been advised by a member of the medical profession to use insulin; or has the Proposed Insured ever had an amputation due to diabetes or other disease?	☐ Yes ☐No	☐Yes ☐No
11. Within the past 24 months, has the Proposed Insured had any diagnostic testing excluding those related to the Human Immunodeficiency Virus (AIDS virus) or any medical procedure recommended by a member of the medical profession that hasn't been completed, or test results excluding those related to the Human Immunodeficiency Virus (AIDS virus) the Proposed Insured hasn't yet received?	☐ Yes ☐No	☐Yes ☐No
12. Within the past 12 months, has the Proposed Insured been diagnosed, hospitalized, treated or advised by a member of the medical profession to have treatment for (including prescription medications): heart attack, stroke or Transient Ischemic Attack (TIA), aneurysm, angina pectoris, any cardiovascular surgery, or has the Proposed Insured been advised by a member of the medical profession to have an implanted pacemaker?	☐Yes ☐No	☐Yes ☐No
13. Within the past 12 months, has the Proposed Insured used or been advised by a member of the medical profession to use **OXYGEN** in connection with treatment for Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, emphysema, asthma or other lung disease?	☐Yes ☐No	☐Yes ☐No
14. Within the past 12 months, has the Proposed Insured been treated for or advised by a member of the medical profession to receive treatment for alcohol or drug use?	☐Yes ☐No	☐Yes ☐No
15. Is the Proposed Insured under age 65 AND receiving social security disability benefits?	☐ Yes ☐No	☐Yes ☐No
16. Within the past 12 months, has the Proposed Insured CHEWED TOBACCO, or SMOKED AND been diagnosed, treated (including prescription medications) or advised by a member of the medical profession to have treatment for Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, emphysema, asthma or other lung disease?	☐ Yes ☐No	☐Yes ☐No

17. Does your weight fall outside the guidelines for your height on the Weight Table below?	☐Yes ☐No	☐Yes ☐No

Weight Table

HGT	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3	6'4	6'5
Min	88	90	93	95	98	101	104	106	110	113	117	120	125	129	133	136	140	143	148
Max	206	213	220	227	234	241	248	256	263	271	279	287	295	303	312	320	329	337	346

*** If all questions in Section A are answered "NO", proceed to Section B**

If all questions in Section A are answered "NO", and any question in Section B is answered "Yes", the Proposed Insured is only eligible for the Graded Death Benefit, Form Number ICC16 LN-1001 GDB.

Section B	**Applicant 1**	**Applicant 2**
1. Within the past 24 months was the Proposed Insured diagnosed, treated for, or advised by a member of the medical profession to receive treatment for heart attack, stroke, Transient Ischemic Attack (TIA), aneurysm, angina pectoris, or any cardiovascular surgery?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 24 months were you diagnosed, treated for (including prescription medications and inhalers), or advised to receive treatment by a member of the medical profession for Chronic bronchitis, emphysema, asthma, Chronic Obstructive Pulmonary Disease (COPD), or any other lung disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 24 months was the Proposed Insured diagnosed, treated for, or advised by a member of the medical profession to receive treatment for liver disorder or kidney disease without dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
4. Within the past 24 months has the Proposed Insured had or been advised by a member of the medical profession to receive treatment for alcohol and/or drug use?	☐ Yes ☐ No	☐ Yes ☐ No
5. Within the past 24 months did the Proposed Insured receive treatment by a member of the medical profession or have a surgery for an aneurysm?	☐ Yes ☐ No	☐ Yes ☐ No
6. Does the Proposed Insured have a pacemaker that was implanted more than 12 months prior to the date of the application?	☐ Yes ☐ No	☐ Yes ☐ No

If all questions in sections A and B are answered "No", the proposed insured qualifies for the Survivor Level Benefit Plan, Form Number LN-1001.

Please list all physicians and hospitals used by the applicant(s) in the last 24 months:

Applicant Name	Physician/Hospital Name	Address	Phone Number

1. Owner (Complete only if other than Proposed Insured)

Name:

First Middle Last

Address:

Street Address City State Zip Code

Phone Number:	Social Security Number:	Date of Birth:
( )	/ /	/ / MM/ DD /YYYY

Relationship to Insured:

2. Insurance Applied For

Policy Type:

☐ LifeShield Individual Survivor (Level Benefit)

☐ LifeShield Individual Survivor (Graded Death Benefit)

☐ LifeShield Joint Survivor (Level Benefit)

☐ LifeShield Joint Survivor (Graded Death Benefit)

Insurance Amount: $_____ **Initial Premium Amount:** $_____

Automatic selection and insurance amount adjustment – Owner agrees that if: (i) selecting but not qualifying for, based on the information in this application, LifeShield Survivor (Level Benefit) the owner is instead automatically applying this application for LifeShield Survivor (Graded Death Benefit).

Automatic premium loan provision elected? ("Yes" or "No" must be selected) ☐ Yes ☐ No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any. If "No", the certificate's Non-forfeiture provision will automatically apply, if premium is overdue at the end of the grace period, resulting in either reduced coverage or surrender.

3. Settlement Options (Please select between Supplemental Income and One Time Payout.)

Supplemental Income: Equal monthly payments for the number of months elected.

☐ $_____ in Monthly Income for _____ months.

One Time Payout: One lump sum payout of the death benefit.

☐ $_____ Death Benefit

*** Unless otherwise stated by the owner prior to the death of the Insured, the beneficiary at claim time can choose to have the face amount of the policy paid in cash or monthly income for selected monthly periods or combination of income and cash.**

4. Payment Information

Payor Name *(first, middle, last)* _____

Payor Address *(Street, City, State, Zip)* _____

Relationship if other than applicant _____

First Premium Payment Provided by ☐ Pre-Authorized Check (PAC) (Complete Payment Form)

Subsequent Premium Payments Made by: ☐ Pre-Authorized Check (PAC) (Complete Payment Form) ☐ Direct Bill

Payment Mode: ☐ Monthly (PAC Only) ☐ Quarterly ☐ Semi-Annual ☐ Annual

Draft date being requested: Draft on the _____ day (choose between 1st and 28th) of the month, beginning in _____(month and year).

5. Agreements

I, the proposed insured and/or owner, declare that I have reviewed all of the statements and answers as they pertain to me, and that they are true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for an insurance contract (defined as a policy), if any, issued by LifeShield National Insurance Co. A Material Misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. No producer, medical examiner, or any other person, except LifeShield National Insurance Co.'s President or Vice-President, has power on behalf of LifeShield National Insurance Co. to make, modify, or discharge an insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. LifeShield National Insurance Co. will have no liability until the policy date of the policy issued based on this application, the first premium due is paid in full on the policy date, and provided that there has been no change in either an answer to an application question or the proposed insured's health between the date this application was signed and the policy date of the insurance contract. This application shall form part of the entire contract with LifeShield National Insurance Co. This application and related documents may be sent by electronic means. If I have chosen to provide an email address in this application or choose to provide one in the future. LifeShield National Insurance Co. may use that address to send messages or documents to me electronically. LifeShield National Insurance Co. may require and obtain information about me to validate my identification.

FRAUD NOTICE/WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

6. Authorization to Obtain and Disclose Information

"Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage and/or benefit claim, I, the proposed insured, authorize LifeShield National Insurance Co. and its authorized persons, to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer, benefit plan, other insurer, or institution; consumer reporting agency; public records, pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition, drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the proposed insured, authorize LifeShield National Insurance Co. and its authorized persons, to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among LifeShield National Insurance Co. and its authorized persons; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization shall remain valid from the date this application is signed for the time limit permitted by the applicable law in the state where the policy is issued or delivered. A copy of this authorization shall be valid as the original. This authorization may be revoked at any time by written notice to LifeShield National Insurance Co., except that action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have been provided the Notices.

7. Signature Section (Review entire Application before signing)

X _____ Signed on: _____ Signed at: _____
Applicant 1's Signature | Date (mm/dd/yyyy) | (City, State)

X _____ Signed on: _____ Signed at: _____
Applicant 2's Signature | Date (mm/dd/yyyy) | (City, State)

X _____ Signed on: _____ Signed at: _____
Owner's Signature (If other than Proposed Insureds) | Date (mm/dd/yyyy) | (City, State)

8. Producer Certification

I certify the following: I am not aware of undisclosed information about the health, personal information, or lifestyle of the proposed insured(s) that might affect insurability. All questions, to which an answer is shown, were asked as written in this application, by me in person. The answers given by the proposed insured(s) were recorded as shown on this application which was reviewed with him/her before it was signed.

Producer's Full Name: _____ Producer's Number: _____

Producer's Signature: _____ Date: _____

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER
LIFESHIELD NATIONAL INSURANCE COMPANY®

THIS FORM MUST BE COMPLETELY FILLED OUT TO BE ACCEPTED

Proposed Insured's Name	Policy Number(Home Office Only)

If the account to be drafted is a Dedicated (Checking or Savings) or Savings account, fill in the shaded boxes. If this is a **Personal/Business Checking Account, you must attach a voided check for processing.** Staple voided checks on the box below.

SEG Name(Selected Employer Group) if applicable:	
Name of Financial Institution	
Address & Phone Number of Financial Institution	
Transit No. & Routing	Savings or Dedicated Account No.

Bank account is (Check appropriate box)

☐ Personal checking account
☐ Personal savings account
☐ Corporate/Business checking account
☐ Dedicated Draft checking account
☐ Dedicated Share savings account

Purpose for submitting this authorization (Check appropriate box/boxes):

☐ New pre-authorized payment plan
☐ Change in checking account
☐ Change in savings account
☐ Change in Dedicated account noted above
☐ Change in bank
☐ Addition of new policy to plan
☐ Change in existing coverage

Desired date for withdrawal from checking/savings account.(Any date between the 1st and 28th of each month) _____
TOTAL AMOUNT OF PAYMENT FOR THIS POLICY $_____

Withdraw My Payment: ____ Monthly ____ Quarterly ____ Semi-Annually ____ Annually

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to LifeShield National Insurance Co. provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LIFESHIELD NATIONAL INSURANCE CO. ®:

It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by LifeShield. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by LifeShield if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by LifeShield upon 30 days written notice.

Print name as it appears on account	Date
Signature of depositor	

LifeShield National Insurance Co.
P.O. Box 1626
Duncan, Oklahoma 73534-1626
Phone: (800) 580-7211

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? YES NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are to the best of my knowledge, accurate:

Applicant's Signature and Printed Name _____ Date _____

Producer's Signature and Printed Name _____ Date _____

I do not want this notice read aloud to me._____(Applicants must initial only if they do not want the notice read aloud.)

SAMPLE ACCELERATED DEATH BENEFIT CALCULATION

If the request for the Accelerated Benefit payment is approved and paid:

- The death benefit, the Policy's base premium, the cash value, and any Policy loans will be reduced on a pro-rata basis.
- The payment will have the following effect on provisions of the policy:

	Before Accelerated Benefit Payment	**After Accelerated Benefit Payment**
Death Benefit	$50,000	$25,000
Annual Base Premium for Policy:	$102.50	$51.25
Cash Value:	6,200.00	3,100.00
Policy Loan:	3,000.00	1,500.00
Accelerated Benefit Requested	$25,000.00	*No longer in force*
Less interest discount at 10%	$2,272.73	
Less Administrative Charge	$100.00	
Less Partial Policy Loan Payoff	$1,500.00	
Net Payment	$21,127.27	
Annual Premium for Rider:	None	*No longer in force*

I acknowledge receipt of a copy of the Accelerated Death Benefit disclosure and sample illustration.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

LifeShield National Insurance Co.

Effect of Accelerated Benefit Payment on Other Benefit Provisions

(a) Description of Benefit: Upon determining that, with reasonable medical certainty, a medical condition will result in the death of the Insured within 12 months or less, we will provide an accelerated death benefit. The amount of accelerated benefit provided shall be as requested by the Owner. The benefit may be up to 100% of the then current policy face amount, subject to a maximum of $100,000, limited to the actual death benefit payable at the time the request is made.

(b) Description of all Qualifying Events: The only qualifying event is that a physician states with reasonable medical certainty that a medical condition will result in the death of the Insured within 12 months or less from the date of the physician's statement. This statement must take into consideration the ordinary and reasonable medical care, advice and treatment available in the same or similar communities.

(c) Cost of Benefit: There is no separate premium for this Benefit, but the Benefit will be discounted for 12 months' interest. The interest rate used in the calculation will be the greater of: (a) The current yield on 90-day treasury bills available on the date of the request, and (b) The current maximum adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages – Monthly Average Corporates, for the calendar month ending two months before the date of request and there will also be an administrative charge of not more than $100.

(d) Description of the Effects on the Remaining Policy: The face amount, guaranteed cash value, actual cash value and gross premium will be reduced by the benefit ratio times the respective amounts. **Benefit Ratio** means the result of dividing the requested accelerated death benefit by the policy face amount. Any outstanding loan and loan interest will be reduced by the portion repaid by any benefit payment under this rider. Any portion of the policy face amount remaining after payment of a benefit and related charges or interest will be paid upon the death of the insured subject to the terms and conditions of your policy.

(e) An administrative expense charge and an interest charge may apply at the time of acceleration.

(f) The acceleration of life insurance benefits (ALBR) offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the ALBR qualify for such favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. Tax laws relating to ALBR are complex. Consult with a qualified tax advisor about circumstances under which you could exclude ALBR from income under federal law.

(g) There are circumstances when receipt of accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor.

(h) Receipt of accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

(i) Accelerated benefits do not and are not intended to qualify as long-term care insurance.