NEA Valuebuilder Program

Security Benefit®

NEA Valuebuilder Program®
Surrender Charge Waiver

Questions? Call our National Service Center at 1-800-NEA-VALU (632-8258).

Definition of Terms

For the purposes of the Surrender Charge Waiver form, the following definitions shall apply:

Hospital

A "hospital" is a lawfully operated institution that is licensed as a hospital by the Joint Commission of Accreditation of Hospitals or any lawfully operated institution that provides in-patient treatment of sick and injured persons through medical, diagnostic and surgical facilities under the direction of a staff of physicians and also provides 24-hour nursing services.

Qualified

A "qualified skilled nursing facility" (or, for Texas residents, a "convalescent nursing home") is a facility licensed by the state to provide convalescent or chronic care for inpatients on a daily basis who, by reason of illness, infirmity or injury, are unable to properly care for themselves.

For Pennsylvania residents, a hospital or qualified skilled nursing facility need not be licensed for you to be eligible to receive this benefit if the hospital or qualified skilled nursing facility to which you are confined is not required by applicable law to be so licensed.

Terminal Illness

A "terminal illness" is an incurable condition that with a reasonable degree of medical certainty will result in death within one year from the date of the Physician's Statement.

For Massachusetts residents, a "terminal illness" is an incurable condition that with a reasonable degree of medical certainty will result in death within 24 months from the date of the physician's statement.

Disability

A "Disability" is defined as: (1) the Owner is unable, because of physical or mental impairment, to perform the material and substantial duties of any occupation for which the Owner is suited by means of education, training or experience; (2) the impairment has been in existence for more than 180 days and began before the Owner attained age 65 and after the Contract Date; and (3) the impairment is expected to result in death or be long-standing and indefinite.

For Massachusetts residents, to be totally and permanently disabled means: (1) unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity; (2) having a level of disability similar to the level of disability described above; or (3) substantial supervision required for protection from threats to health and safety due to severe cognitive impairment.

Please keep the Definition of Terms for your records.

Please separate here

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Instructions

This form must accompany each withdrawal requested under the Surrender Charge Waiver Option. Certify your reason for waiver and have your physician complete and sign the Physician's Statement Section. You may reference the definition of each waiver provided or your Contract for more details. Please type or print.

1. Provide General Account Information

Contract Number _____

Name of Owner _____ _____ _____
First MI Last

Mailing Address _____ _____ _____ _____
Street Address City State ZIP Code

Social Security Number/Tax I.D. Number _____

Daytime Phone Number _____ Home Phone Number _____

2. Hospital/Nursing Home Certification

Name of Hospital/Nursing Home _____

Address of Hospital/Nursing Home _____ _____ _____ _____
Street Address City State ZIP Code

Date of Entry to Hospital/Nursing Home _____
(mm/dd/yyyy)

Expected Period of Confinement _____

I hereby certify that (1) I have been confined to a "Hospital", "Qualified Skilled Nursing Facility" or "Convalescent Nursing Home" for a minimum of the last 90 consecutive days, (2) I am still confined and (3) confinement began after the date my Contract was issued to me.

X_____ _____
Signature of Owner Date (mm/dd/yyyy)

3. Disability Certification

This option may not be available. Please refer to your Contract.

Date of Birth _____
(mm/dd/yyyy)

Nature of disability: _____

_____

_____

I hereby certify that I am totally and permanently disabled.

X_____ _____
Signature of Owner Date (mm/dd/yyyy)

4. Terminal Illness Certification

Nature of illness:_____

_____

_____

I hereby certify that I have been diagnosed by a licensed physician as having a terminal illness.

X_____ _____
Signature of Owner Date (mm/dd/yyyy)

5. Physician's Statement

Physician's Name_____ _____ _____
First MI Last

Physician's Address _____ _____ _____ _____
Street Address City State ZIP Code

Physician's Phone Number _____

I, _____
Physician's Name

a duly licensed physician, hereby certify that

_____
Owner's Name

❍ is confined to a hospital or qualified skilled nursing facility, **or**

❍ has a physical or mental impairment (disability), which is expected to result in death or be long-standing and indefinite, **or**

❍ has been diagnosed with a terminal illness.

Date disability or illness was diagnosed _____
(mm/dd/yyyy)

Additional comments: _____

_____

_____

X_____ _____
Signature of Physician Date (mm/dd/yyyy)

Mail to: Security Benefit • PO Box 750497 • Topeka, KS 66675-0497 or
Fax to: 1-785-368-1772
Visit us online at www.neamb.com