For use with R6032310CA and R6032610CA

MassMutual Ascend Life Insurance Company

Affiliate:
Annuity Investors Life Insurance Company®
Fixed & Fixed Indexed Annuities: PO Box 5420, Cincinnati OH 45201 / 800-854-3649 / 800-482-8126 Fax
Registered Index-Linked Annuities Only: PO Box 5423, Cincinnati OH 45201 / 800-789-6771 / 800-807-9777 Fax
Overnight Address: 191 Rosa Parks St, Cincinnati OH 45202

STATEMENT OF CLAIM—TERMINAL ILLNESS REQUEST

For use with contracts issued in California on or after January 1, 2013

	Contract/Certificate Number
Name of Owner(s)	Owner Social Security No/Tax Id No
Address of Owner(s)	Owner Daytime Phone ( )
Name of Insured (if different)	Insured Social Security No
Address of Insured	Insured Daytime Phone ( )

Instructions

1. Complete this side of form only. Please answer all questions.
2. Both the Owner and the Insured must sign and date this form.
3. The attending Physician must complete and sign the reverse side of this form.
4. Forward completed form to the address listed at the top of this form.

1. Medical Information

Please describe in detail the nature of your illness:

Name of Attending Physician:

2. Distribution Type (Note: For either option, additional forms **ARE** needed. Contact MassMutual Ascend or Affiliate.)

☐ Full Surrender ☐ Partial Surrender

3. Authorization to Release Information and Certification

I hereby authorize any Physician to release any information requested by MassMutual Ascend or Affiliate or its representative.
I hereby certify this Statement of Claim is true, complete and accurate.

Signature of Insured | Date | Signature of Owner (if different) | Date

For your protection California law requires the following statement to be included in this form. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.
The issuing MassMutual Ascend or Affiliate reserves the right to investigate any claim and to take appropriate action based on such investigation. You are entitled to appeal any denial of a claim. A written appeal must be made within 30 days of receipt of the denial.

PHYSICIAN'S STATEMENT

1. Patient Information

Patient's Name:

Date patient first consulted you for this illness:

Diagnosis of illness:

Life Expectancy: As a result of the illness, does the patient have a life expectancy of less than twelve (12) months from the date of diagnosis?

☐ YES

☐ NO

2. Physician's Information

Name	Office Phone Number ( )
Address	
City/State/Zip	

3. Physician's Certification

I hereby certify I am a Physician as defined below and this Physician's Statement is true, complete and accurate.

Physician's Signature Date

Physician means a licensed medical doctor (M.D.), or a licensed doctor of osteopathy (D.O.) practicing within the scope of his or her license.

Note: The term "Physician" does not include an Owner or joint owner; an Insured; a Family Member of an Owner, joint owner, or Insured; or an employee, officer, owner, partner, member, or agent of a non-natural person Owner or joint owner. **Family Member** means spouse, parent, grandparent, child, grandchild, sibling, aunt, uncle, first cousin, niece, or nephew, or any such relative by marriage or adoption, including in-laws and step-relatives.