For use with R6026109CA, R6026209CA,
R6032410CA and R6032710CA (6/1/2021)

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: 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
FACILITY CARE OR HOME CARE OR COMMUNITY-BASED SERVICES 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's Social Security No	
Address of Insured		Insured Daytime Phone ( )

Instructions

1. Provide all information requested in this form.
2. Both the Owner and the Insured must sign and date this form.
3. Each prescribing Physician, Registered Nurse or Licensed Social Worker must complete and sign a copy of the Statement included in this form.
4. Forward completed form and Statement(s) to the address listed at the top of this form.

The following terms are defined on page 3 of this form. Please refer to the definitions when completing this form.

Facility	Home Care or Community-Based Services	Physician
Skilled Nursing Facility	Home Health Care	Registered Nurse
Convalescent nursing home	Adult Day Care	Licensed Social Worker
Extended care facility	Personal Care	Family Member
Residential care facility	Homemaker Services	
Residential care facility for the elderly	Hospice Services	
	Respite Care	

1. Claim Type

Instructions: Please check appropriate box and provide requested explanation.

☐ Insured's Confinement in Facility

☐ Insured's Receipt of Home Care or Community-Based Services

☐ Insured's Confinement in Facility **and** Receipt of Home Care or Community-Based Services

Reason for Confinement and/or Receipt of Services Please describe in detail the reason(s) Insured is confined in a Facility and/or receiving Home Care or Community-Based Services

2. Information about Confinement and/or Receipt of Services

Instructions: Provide information for each applicable item.

☐ **Confinement in Facility**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

Name of Facility

Address of Facility

Phone Number of Facility | Fax Number of Facility

☐ **Home Health Care**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

☐ **Adult Day Care**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

☐ **Personal Care**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

☐ **Homemaker Services**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

☐ **Hospice Services**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

☐ **Respite Services**
Name of prescribing Physician, Registered Nurse or Licensed Social Worker

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

Instructions: Please check **one** box to indicate the type of distribution you would like to receive.

☐ Full Surrender ☐ Partial Surrender ☐ Settlement Option Election ☐ Easy Systematic Payment Program

4. Authorization to Release Information and Certification

I hereby authorize any Facility, Physician, Registered Nurse or Licensed Social Worker 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 do not waive 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.

Definitions

Facility means:
- a Skilled Nursing Facility, as defined in the Medicare program;
- a convalescent nursing home, as defined in the Medicare program;
- an extended care facility, as defined in the Medicare program;
- a residential care facility, as defined in the California Health and Safety Code; or
- a residential care facility for the elderly, as defined in the California Health and Safety Code.

Home Care or Community-Based Services means home health care, adult day care, personal care, homemaker services, hospice services and respite care as each is defined below.
- **Home Health Care** is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- **Adult Day Care** is medical or nonmedical care on a less than twenty-four (24)-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
- **Personal Care** is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
- **Homemaker Services** is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **Hospice Services** are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **Respite Care** is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home.

Physician means a person who is licensed in the United States as a medical doctor (M.D.) or a doctor of osteopathy (D.O.) and who is practicing within the scope of his or her license.

Registered Nurse means a person who is licensed in the United States as a nurse and who is practicing within the scope of his or her license.

Licensed Social Worker means a person who is licensed in the United States as a social worker and who is practicing within the scope of his or her license.

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

STATEMENT OF PRESCRIBING PHYSICIAN, REGISTERED NURSE OR LICENSED SOCIAL WORKER

Instructions: **Each** Physician, Registered Nurse and Licensed Social Worker who has prescribed Facility Care or Home Care or Community-Based Services for the Insured, as indicated above, must complete a copy of this Statement.

1. Information about Patient

Name of Patient

Date of First Consultation with Patient

2. Information about Prescribing Professional

Name of Prescribing Professional

Office/Daytime Phone Number

Address

Professional Designation

☐ Physician ☐ Registered Nurse ☐ Licensed Social Worker

3. Information about Prescribed Services

Instructions: Check the applicable box or boxes to indicate the services you have prescribed for this patient and provide requested information about those services. Words and phrases in bold and italics are defined below.

☐ Confinement in Facility

1. Reason for prescribing confinement in ***Facility***

2. Name and address of ***Facility***

3. Type of ***Facility***

   ☐ ***Skilled Nursing Facility***
   ☐ ***Convalescent Nursing Home***
   ☐ ***Extended Care Facility***
   ☐ ***Residential Care Facility***
   ☐ ***Residential Care Facility for the Elderly***

4. Date on which confinement in ***Facility*** began

5a. Date on which confinement ended If confinement has not ended, complete 5b below.

5b. Anticipated length of confinement Please provide an explanation for your answer.

☐ Home Health Care

1. Reason for prescribing ***Home Health Care***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

☐ Adult Day Care

1. Reason for prescribing ***Adult Day Care***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

☐ Personal Care

1. Reason for prescribing ***Personal Care***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

☐ Homemaker Services

1. Reason for prescribing ***Homemaker Services***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

☐ Hospice Services

1. Reason for prescribing ***Hospice Services***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

☐ Respite Care

1. Reason for prescribing ***Respite Care***

2. Description of services

3. Date on which services began

4a. Date on which services ended (If services have not ended, complete 4b below.)

4b. Anticipated date on which services will end (Please provide an explanation for your answer.)

4. Certification (Please sign the Certification that applies to you.)

Physician I certify I am a Physician as defined below and the information I provided is true, complete and accurate.

Physician's Signature _____ Date _____

Registered Nurse I certify I am a Registered Nurse as defined below and the information I provided is true, complete and accurate.

Registered Nurse's Signature _____ Date _____

Licensed Social Worker I certify I am a Licensed Social Worker as defined below and the information I provided is true, complete and accurate.

Licensed Social Worker's Signature _____ Date _____

Facility means:
- a Skilled Nursing Facility, as defined in the Medicare program;
- a convalescent nursing home, as defined in the Medicare program;
- an extended care facility, as defined in the Medicare program;
- a residential care facility, as defined in the California Health and Safety Code; or
- a residential care facility for the elderly, as defined in the California Health and Safety Code.

Home Care or Community-Based Services means home health care, adult day care, personal care, homemaker services, hospice services and respite care as each is defined below.
- **Home Health Care** is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- **Adult Day Care** is medical or nonmedical care on a less than twenty-four (24)-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
- **Personal Care** is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
- **Homemaker Services** is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **Hospice Services** are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **Respite Care** is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home.

Physician means a person who is licensed in the United States as a medical doctor (M.D.) or a doctor of osteopathy (D.O.) and who is practicing within the scope of his or her license.

Registered Nurse means a person who is licensed in the United States as a nurse and who is practicing within the scope of his or her license.

Licensed Social Worker means a person who is licensed in the United States as a social worker and who is practicing within the scope of his or her license.

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