



Guarantee Trust Life Insurance Company • P.O. Box 1148 • Glenview, IL 60025
 Group Claim Department Phone Number: 800-622-1993 • FAX: 847-803-1835
 Email: Special_riskdiv@gtlic.com

ACCIDENT MEDICAL CLAIM FORM

TO BE COMPLETED BY INSURED MEMBER

Policy/Plan Number: _____

Name of Insured Member: _____ Alternate Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone Number: (____) _____ - _____ Insured Member Date of Birth: ____/____/____

Social Security Number/Member Identification Number: _____

Patient's Name and Relationship (If other than Insured Member): _____

Patient's Date of Birth: ____/____/____ Male Female

1. Date of Accident: ____/____/____ 1a. Hour: ____:____ AM PM

2. Description of Accident:

A) How did it occur? _____

B) Where did it occur? City: _____ State: _____ Location: _____

C) Nature of Injury? _____

3. Were you hospitalized? Yes No

3a. If Yes, please give Name and Address of Hospital: _____

4. Did this accident occur while playing in an Organized Sport? Yes No

5. Was this a work related accident/injury? Yes No

5a. If Yes, has this been filed with Workers' Compensation? Yes No

6. Have you ever had this Condition before? Yes No

6a. If Yes, please give month, date and year: ____/____/____

7. Is the Patient covered by any other plan for expenses related to this accident? Yes No

7a. If Yes, please give the following information of the Insurance Carrier:

Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone Number: (____) _____ - _____ Policy Number: _____

Effective Date: ____/____/____ Termination Date (if applicable): ____/____/____

PLEASE NOTE: Incomplete claim forms will result in process delay.

I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy.

 Signature of Insured Member Date: ____/____/____

 Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

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I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Member Signature: _____ **Print Name:** _____ **Date:** ____/____/____

CLAIM FILING PROCEDURE

Proof of Loss (Completed claim form and itemized bills) must be submitted within 90 days of the accident or commencement of sickness, additional bills must be submitted within 90 days of the date of treatment.

- The front side of this form must be completed and signed by the Insured.
- Attach itemized bills indicating the date(s) of treatment, type(s) of service, diagnosis and charges for each treatment.
- Please also attach, if applicable, a copy of the "Explanation of Benefits" statement from your other Insurance Carrier showing their process of the submitted expenses.
- Return the completed claim form and bills to Guarantee Trust Life Insurance Company, PO Box 1148, Glenview, IL 60025. Also, please indicate which bill(s) have been paid by you.

* Incomplete claim forms will result in a processing delay.

Only one claim form is needed per condition. Bill(s) for follow-up treatment should indicate your name, policy number and/or the name of your organization and if the bill(s) are for treatment for a previously submitted claim.

ATTENDING PHYSICIAN'S STATEMENT

* Each Doctor's bill attached must have the Doctor's Federal Tax ID # (TIN) or Social Security Number (SSN) *

This Statement MUST be completed by the Attending Physician

1. Patient's Name: _____
2. Nature of Sickness or Injury (Describe complications if any) _____

3. When did symptoms first appear or accident happen? ____/____/____ (Please give month, date and year)
4. When did Patient first consult you for this condition? ____/____/____ (Please give month, date and year)
5. Has Patient ever had same or similar condition? Yes No
- 5a. If Yes, state when: ____/____/____ Describe: _____

6. Please give date(s) of treatment: ____/____/____ ____/____/____ ____/____/____
____/____/____ ____/____/____ ____/____/____

Doctor's Signature: _____ Degree: _____ Date: ____/____/____

TIN or SS#: _____ (MUST BE COMPLETED)

Address: _____
Street City State Zip Code

Phone Number: (____) ____-____

*** IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS for the date of treatment accompanied by any bill(s) incurred to that date.**

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

**Alabama
Arkansas
California
Connecticut
Georgia
Iowa
Illinois
Kansas**

**Louisiana
Massachusetts
Maryland
Michigan
Missouri
Mississippi
Montana
North Carolina**

**North Dakota
Nebraska
Nevada
Puerto Rico
Rhode Island
South Carolina
South Dakota**

**Texas
Utah
Vermont
Wisconsin
West Virginia
Wyoming**

Generic Fraud Warning (to be used for above states only)

Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alaska, Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Colorado, D.C., Hawaii, Maine, Tennessee, Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance coverage.

Arizona, Minnesota, New Jersey, New Mexico

IN 12 POINT TYPE FOR ALL STATES LISTED TO SATISFY ARIZONA REQUIREMENTS - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon

Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida

Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

New Hampshire

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

GUARANTEE TRUST LIFE INSURANCE COMPANY

PO Box 1148
Glenview, Illinois 60025
1-800-622-1993

AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes) any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager or Human Resources.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

(Print Please) Name of Patient

Signature of Patient and Date

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin and Date