TRANSAMERICA

Supplemental Health

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

Fax Number: 866-586-6528

Instructions for Submitting a Claim

You can submit this claim through our website at www.transamericaemployeebenefits.com. This Health Claim Package consists of multiple parts. When filling out each section of the package, please keep in mind that you should provide complete and accurate information. If you make a claim on your dependent who is over the age of 18, the claimant (patient) needs to sign and date the HIPAA Authorization for the Release of Health-Related Information ("HIPAA Authorization Form" which is available to you in this package below). You cannot sign this form for the dependent. Take a moment, also, to verify that the doctor completing the Attending Physician's Statement answers all questions and signs and dates the form.

Here are some other common documents and statements needed when filing certain types of health claims. It's important to note that the list of forms and information within each claim type are generic. Proof of Treatment can be an itemized bill from your doctor showing the treatment received and diagnosis; an invoice; or an itemized summary, including the UB-04 or CMS1500 forms.

For all claims, the following documents are REQUIRED:

- Claimant's Statement
- Attending Physician's Statement
- HIPAA Authorization

Additional documentation required for specific claims types:

Accident*

- Employer's/Business Entity's Statement if filing for the Disability Riders
- Statement(s) showing actual charges/expenses for medical treatment or diagnosis
- Proof of loss - such as hospital statement, ambulance statement, and/or physical therapy

Disability

- Employer's/Business Entity's Statement
- Statement(s) showing actual charges/expenses for medical treatment or diagnosis
- Police report if disability is a result of a motor vehicle accident
- Discharge summary (if disability began with an emergency room visit)
- First report of the injury (if disability was an on-the-job accident)

Critical Illness*

- Diagnostic reports (a pathology report if cancer-related)
- Discharge summary or other medical records indicating the condition and date of diagnosis

Cancer*

- Pathology report diagnosing cancer
- Itemized provider statements with actual charges/expenses(**) incurred for the treatment

Heart/Stroke**

- All itemized hospital statements with actual charges/expenses incurred for treatment

Intensive Care/Hospital Indemnity

- Itemized hospital or UB04 statements
- (ICU Coverage only) Ambulance statement if transported

*For Wellness Screening Benefit, you only need to submit statements or medical records from the physician or hospital showing the date and procedure performed. No additional documents are necessary.
**If you are covered by Medicare or Medicaid or other insurance, please submit statements from doctor/medical provider/hospital showing payments or adjustments by Medicare, Medicaid, or your other insurance. You also must send any other information showing the actual charges or expenses incurred for your treatment, which includes copies of all summary notices from Medicare or Medicaid, or explanations of benefits from your other insurance.

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Supplemental Health Insurance Claim Form

PO Box 869097 Plano, TX 75086-9817
Fax Number: 866-586-6528
E-mail: TEBclaimsscanning@transamerica.com
Questions Call: 888-763-7474

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

CLAIMANT'S STATEMENT

For which policy(ies) is a claim being filed? Please check all that apply:

Accident ___ Disability ___ Critical Assistance ___ Cancer ___ Heart/Stroke ___ Intensive Care / Hospital Indemnity ___

1.[Primary] Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Social Security Number
5a. Mailing Address			6. Phone Number
5b. Street Address			7.Email Address
8. Patient's Full Name	9. Date of Birth		10. Relationship to Insured

ONLY COMPLETE THE INFORMATION THAT APPLIES TO YOUR LOSS

If additional space is needed for any question, please use an additional sheet of paper and attach to this form.

1. Nature of injury or illness	
2. When did symptoms first appear or accident occur? If an injury, explain fully how, when, and where accident occurred.	3. Date first treated/diagnosed

4. Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No Do you have other health insurance? ☐ Yes ☐ No If yes, what company?

Please continue onto next page

DISABILITY ONLY: If you are filing as a result of an accident or sickness, please complete this section and have the attached Employer's Business Entity Statement completed by your employer

To the best of your knowledge, indicate if you have filed for or are receiving income from any of the following sources:

Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____

EIB/PTO ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____

	Applied For	Receiving	Amount	Frequency	From/To Dates
Short Term Disability	☐	☐	$_____	_____	_____/_____
Worker's Compensation	☐	☐	$_____	_____	_____/_____
State Disability	☐	☐	$_____	_____	_____/_____
Social Security	☐	☐	$_____	_____	_____/_____
Dependent Social Security	☐	☐	$_____	_____	_____/_____
No Fault (Income Replacement)	☐	☐	$_____	_____	_____/_____
Retirement/Pension	☐	☐	$_____	_____	_____/_____
Permanent Total Disability	☐	☐	$_____	_____	_____/_____
Other (Please Identify	☐	☐	$_____	_____	_____/_____

All must sign and date below.

All of the above answers and statements are true and complete, and correctly recorded. I have read and understand the appropriate Fraud Warning. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance coverage in force or payable.

For residents of New York: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____

Claimant Signature

_____

Print Name

_____

Date (mm/dd/yyyy)

Fax Number: 866-586-6528

ATTENDING PHYSICIAN'S STATEMENT				
1. [Primary] Insured's Full Name			2. Policy or Certificate Number	
3. Patient's Full Name			4. Patient's Date of Birth	
5. For this patient: Are you being paid by Medicare? ☐ Yes ☐ No	Are you being paid by Medicaid? ☐ Yes ☐ No	Are you being paid by other health insurance? ☐ Yes ☐ No	If yes, what company?	
6. Diagnosis? (Please use ICD 10 Codes)	7. When did symptoms first appear or accident happen?		8. When did the patient first consult you for this condition?	
9. If the claim is for pregnancy, please give due date and type of delivery.	10. List all dates of treatment, including any surgical procedure(s), and include the date and charges of each treatment/procedure(s). (Please use current CPT codes.)			
11. Is the patient still under your care for this condition? ☐ Yes ☐ No If no, please give name and address of new treating physician. _____	12. Did you advise patient to cease work? ☐ Yes ☐ No If yes: From To		13. Please give dates of disability for this condition. From To	
14. If the patient was released to light duty due to this condition, please give dates. From To	15. Was the patient unable to perform two or more ADL's (Activities of Daily Living) due to this condition? ☐ Yes ☐ No If so, which ones?			
Date	Physician's Name – Print	**Signature**	Degree	Phone Number ( )
Street address	City	State	Zip	Tax Identification Number

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Claims Fax: 866-586-6528
Claims Email: TEBclaimsscanning@transamerica.com
Claims Customer Service: 888-763-7474

DISABILITY ONLY: If you are filing for benefits as a result of an accident or sickness, have the below completed by your employer.

Employer's/Business Entity's Statement (Does not apply to Cancer, Hospital and Critical Illness coverages)

1. Company Name:		2. Phone Number:	
3. Street Address:	4. City:	5. State:	6. Zip Code:
7. Name of Employee/Insured Person:	8. Social Security Number:		

9. IMPORTANT: date Employee/insured person was last actively at work:

10. Employee's/Insured Person's job title/major job duties **(Please attach a copy of job description):**

11a. Did disability occur on the job? ☐ Yes ☐ No

11b. Job Classification: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

12. If employee was medically cleared to return to work with restrictions or on light duty can you accommodate? ☐ Yes ☐ No
If no, please attach a letter stating why accommodation is not possible.

13. Date employee/insured person returned to work: _____
☐ Full Time ☐ Part Time ☐ Light Duty

14. If "Part Time", due to partial disability, provide earnings:
Amount: _____ From/To Dates: _____

15. Employee/Insured Person's status of employment after first day absent:
☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Other: _____

16. Employee/Insured Person's **current** status of employment:
☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Effective: _____

17. Annual Salary :
$ _____

18. To the best of your knowledge, indicate if employee/insured person has filed for or is receiving income from any of the following sources:
Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____
EIB/PTO ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____
Workers Compensation ☐ Yes ☐ No

The above statements are true and complete to the best of my knowledge and belief.

Employer's/Business Entity's Authorized Representative

Name (please print) _____ Title _____ Phone # _____

Signature _____ Date _____

Claim Fraud Warning

State Specific Notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agents of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana: 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.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maine, Tennessee, Virginia, 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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 N. H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the misinformation must be material to the content of the policy, the insurer must rely upon the misinformation and the misinformation must be either material to the risk assumed by the insurer or provided fraudulently. For remedies other than denial of a claim, misstatements, misrepresentations, omissions or concealments must either be fraudulent or material to the interests of the insurer in order for the insurer to assert a right to remedy. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: 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

FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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.

TRANSAMERICA®

HIPAA Authorization for Release of Health- Related Information

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Advisors Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
PO Box 869097 Plano, TX 75086-9817

This authorization complies with the HIPAA Privacy Rule.
A copy of this authorization will be considered as valid as the original.

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, long term care facilities (including assisted living facilities), home health care entities and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the **entire medical record** and any other protected health information concerning the insured/patient to the company(ies) referenced at the top of this authorization (the "Companies"), their affiliates and reinsurers, and any business associate, agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency (including MIB, Inc. formerly known as the Medical Information Bureau) or independent claim administrator acting on behalf of any of the Companies. This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, diagnosis, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), prescription drug information, substance abuse records, medical records, medical notes, and medical recordings. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization and I instruct the Providers to release and disclose the **entire medical record and any other protected health information as noted above** without restriction.

The information disclosed will be used for claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations.

This authorization shall remain in force for 24 months, or in the case of long term care or disability claims for the duration of the claims under such policy, following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Consumer Affairs Department, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies. I understand that I have a right to receive the Notice of Health Information Privacy Practices upon request.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the **entire medical record** of the insured/patient, the Companies may not be able to proceed with claims or eligibility processing or make any benefit payments. I acknowledge that (1) if I am signing on behalf of the insured/patient, I am legally permitted to do so as the personal representative of the insured/patient, and (2) I have received a copy of this authorization.

Name of insured/patient (please print) | Date of birth

Signature of Insured/Patient or Personal Representative of the Insured/Patient | Date

Description of Personal Representative's Authority or Relationship to Insured/Patient

Policy or Contract Number
(for use in Claims processing)

TRANSAMERICA®

Medical History Form

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Advisors Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
PO Box 869097 Plano, TX 75086-9817

Name of Insured	Social Security Number

Policy Number(s)

Please list below the names, addresses, and phone numbers of all medical providers, including doctors and hospitals, consulted or used by the insured for the following dates, beginning _____ through _____.
If more space is needed, please attach additional pages to this form.

Primary/ Family Physician			Phone Number
Street Address	**City**	**State**	**Zip Code**
Reason for Visit			**Dates Consulted or Year Treated**

Provider Name			Phone Number
Street Address	**City**	**State**	**Zip Code**
Reason for Visit			**Dates Consulted or Year Treated**

Provider Name			Phone Number
Street Address	**City**	**State**	**Zip Code**
Reason for Visit			**Dates Consulted or Year Treated**

Name of Insured	Policy Number(s)

Provider Name	Phone Number

Street Address	City	State	Zip Code

Reason for Visit	Dates Consulted or Year Treated

For the dates listed on page 1, the following prescriptions have been filled for the insured (see label on Rx bottle). If more space is needed, please attach additional pages to this form.

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

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Claimant's Signature

Date (mm/dd/yyyy)

Claimant's Printed Name