GTL | GUARANTEE TRUST LIFE

LIFE INSURANCE CLAIM FORM

Please read the important information below:

- ☐ Please be sure the insured's policy number/s is/ are written on ALL documentation.
- ☐ The claim form must be completed and signed by the beneficiary/beneficiaries or executor.
- ☐ If beneficiary/beneficiaries is/are minors, we will need Guardianship papers in order to consider an adult to receive benefits.
- ☐ If the beneficiary/beneficiaries is/are deceased, you will need to include an original death certificate. If the beneficiary pre-deceased the insured, benefits will be made to the Estate of the insured.
- ☐ For a Contestable policy in force less than 2 years at the time of death, you must complete forms A, B & C in the claim form package. Additional medical history information will need to be obtained by us.
- ☐ For policies in force longer than 2 years at the time of death, only forms A & B are required to be completed.
- ☐ If death occurred outside of the United States there may be additional time needed to obtain information and process claim.
- ☐ It is critical that the **HIPAA Authorization** (Form B) must be signed, dated and included with your submission, so that we can contact the Insured's medical provider on their behalf if needed.

Be sure to send:

- ☐ An original "Certified" death certificate with the cause and manner of death shown. If you are submitting the claim electronically, you will still need to mail us an original death certificate.
- ☐ If cause or manner of death is "pending" we will need to wait for the final death certificate.
- ☐ If cause of death was due to an accident, suicide, or homicide, additional information may be necessary such as toxicology, police and autopsy reports. These documents will need to be obtained by the beneficiary.
- ☐ If the policy has an Accidental Death Benefit Rider, those benefits will be reviewed and processed independently from the main Life policy. Even though benefits may be provided on the base coverage, the Accidental Death Benefit may still be under review.
- ☐ Provide the original policy/ies, if available.
- ☐ Any assignments for benefits, such as for Funeral Home arrangements should be included.
- ☐ **Processing delays may result if you do not provide all of the required information. We suggest you make photocopies of any information sent for your own records**

Please send the completed claim form and other documents to:

Guarantee Trust Life Insurance
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to (847) 699-1048
OR Email to: Claims@gtlic.com

SKIP THE CALL. CHAT WITH US INSTANTLY!

*Access your policy information anytime in the Customer Portal and check your claim status **instantly** with our 24/7 chatbot.*

Visit gtlic.com and click Policy Login in the navigation.

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Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or Fax to (847) 699-1048
Or email to: Claims@gtlic.com
For Customer Service, please call: (800) 338-7452

A LIFE INSURANCE CLAIM FORM

BENEFICIARY STATEMENT

Policy Number(s)

Deceased's Full Name Alternate Name

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

Date of Death: _____/_____/_____ Place of Death: _____

Cause of Death: _____ ☐ Accident ☐ Illness

If accident, please give full details (attach newspaper clippings, obituaries etc.):_____

When did the deceased *first complain of*, or give other signs of his/her illness: _____/_____/_____

When did the deceased *first consult* a physician for his/her last illness: _____/_____/_____

Occupation at the time of death: _____

Last day the deceased attended to his/her usual work or activities: _____/_____/_____

Name of Primary Physician _____ Group Practice _____

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

( ) _____

Phone Number Email

Any other physicians or hospitals who attended or treated the deceased in the last 3 years:

Name Address Date Treated Diagnosis/Condition

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 am entitled to receive a copy of this authorization upon request. IMPORTANT – Be sure to sign below AND the provided authorization.

Signature: **as** **(Beneficiary, Executor, etc.)** **Date of Birth:** **Date:**

Printed Name: Social Security Number:

Relationship to Insured: _____

Email

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

( ) _____

Phone Number: Witness:

Guarantee Trust Life Insurance Company
P.O. Box 1144, Glenview, Illinois 60025
1-800-338-7452

B

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

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

Policy/Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. 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. I understand that I am entitled to receive a copy of the Authorization upon request.

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

I understand that GTL 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. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to evaluate claims, and may be a basis for denying a claim for benefits.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Patient _____ Date of Birth _____

(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 _____ Date _____

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Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or Fax to (847) 904-5723
Or email to: LifeClaims@gtlic.com
For Customer Service, please call: (800) 338-7452

C ATTENDING PHYSICIAN'S STATEMENT

Deceased's Full Name _____ Age _____

Alternate Name _____

Place of Death *(If in hospital or institution, give name & Address)* _____

Cause of Death Info: Primary Cause of Death: _____

Contributing Causes: _____

Other Conditions Treated: _____

Length of time the Primary or contributing conditions were present prior to death

Condition _____ Years *(Approximately)* _____ Months _____ Days _____

Condition _____ Years *(Approximately)* _____ Months _____ Days _____

Date of first attendance for this last illness _____

Date of last attendance for this last illness _____

Specify if applicable: *Death was due to:* ☐ Accident ☐ Suicide ☐ Homicide

Please describe briefly: _____

Was an autopsy performed? ☐ Yes ☐ No

If so, with what findings: _____

Was an inquest held: ☐ Yes ☐ No

If so, with what findings: _____

Please list any treatments or medical advice given over the last 5 years:

Date *Condition*

Please list any other physicians who, to your knowledge, gave treatment to the deceased over the last 5 years:

Name *Address* *Details*

Date: _____/_____/_____ Attending Physician's Signature: _____

Name _____

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

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.*

Connecticut
Georgia
Hawaii
Iowa
Illinois
Kansas
Massachusetts
Michigan
Missouri
Mississippi
Montana
Nebraska
North Carolina
North Dakota
Nevada
South Carolina
South Dakota
Utah
Vermont
Wisconsin
Wyoming

General 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.

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, Louisiana, Rhode Island and 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 an 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 agent 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 – 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.

District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A person who knowingly and with intent to defraud any insurance company or other person files a 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 – 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 benefits.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 RSA 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – 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.

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.

Tennessee, Virginia and Washington State – 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.

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.