GTL | GUARANTEE TRUST LIFE

CANCER, HEART ATTACK & STROKE INSURANCE CLAIM FORM
(*For Non-Precision Care Products)

***If Precision Care™ or Precision Medicine Product, you will need to use the specific Precision Care™ claim forms**

Please read the important information below:

- ☐ Please be sure your policy number(s) is/are written on the claim form.
- ☐ The claim form must be completed and signed by the Insured. If claim is for a dependent child under the age of 18, claim form and authorization must be signed by the insured.
- ☐ The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your claim submission, so that we can contact your medical provider(s) on your behalf if additional medical documentation is required in reviewing your claim. Sometimes a provider may require their own Special Release Authorization to be completed. If this should happen, we will advise you.
- ☐ Please attach any itemized bills to the claim form. Please do not submit copies of other insurance carriers statements (EOB) and or provider Account Balance Due Statement(s), as they do not always include the required information (diagnosis code, procedure code, dates of service) that we need in order to review and process your claim. Incorrect statements could result in a delay of your claim.
- ☐ If your coverage provides a Lump Sum Benefit, then instead of a bill just send us a copy of the medical reports or diagnostic tests used to diagnose your condition. See policy for acceptable testing.
- ☐ **Please see page 3 of claim form for what clinical documentation may be needed for your claim, or to file an Accident claim.**
- ☐ **NOTE:** Your Policy may have a Pre-Existing Conditions Limitation and a 2 Year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.
- ☐ If you signed a benefits assignment with the provider and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.
- ☐ Please send the completed claim form, signed HIPAA Authorization, and any itemized bills or documents to:

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

- ☐ For your records, we suggest you make copies of any information you send us.
- ☐ **Processing delays may result if you do not provide all required information.**
- ☐ You can also go online to update your policy information at www.gtlic.com (click on PolicyLogin).

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

CANCER, HEART ATTACK & STROKE INSURANCE CLAIM FORM

TO BE COMPLETED BY THE INSURED

Policy Number(s) _____ Policyholder's Name _____

Claimant/Patient Name _____ Date of Birth _____

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

Phone _____ Email _____

TYPE OF BENEFIT(S) FOR WHICH THE CLAIM IS BEING MADE

- ☐ Cancer (malignant melanoma/adenocarcinoma)
- ☐ Advanced Stage Cancer (Stage III or Stage IV)
- ☐ Heart Attack (myocardial infarction)
- ☐ Stroke/CVA (cerebral vascular accident)
- ☐ Cancer In Situ (Stage 0 or early stage cancer)
- ☐ Skin Cancer (Basal Cell Carcinoma or Squamous Cell Carcinoma)
- ☐ ICU (intensive care)
- ☐ Transplant
- ☐ Coronary Artery Bypass or Angioplasty
- ☐ Dental and Vision
- ☐ Experimental Treatment
- ☐ Critical Accident (go to page 3)

Date symptoms first appeared: ___/___/___ Date of first visit with physician? ___/___/___

Date of actual/definitive diagnosis: ___/___/___

Have you ever had this illness/condition before? ☐ Yes ☐ No If yes, date? ___/___/___

If yes, what's the name, address and telephone number of physician? _____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center? _____

Primary Care (family doctor) name, address and telephone number: _____

Where there any other physicians seen during the last two (2) years? *(if more space is needed, please attach separate sheet)*
If so, please provide their names, addresses and phone numbers:

Physician name, address and phone number : _____

Physician name, address and phone number : _____

Physician name, address and phone number : _____

DOCUMENTATION TO PROVIDE WHILE FILING FOR SPECIFIC BENEFITS

CANCER OR SKIN CANCER CLAIMS:

Submit the pathology report diagnosing cancer. This must accompany your initial claim for that diagnosis of cancer. The hospital, doctor or pathology laboratory will furnish this report to you at your request. If the diagnosis of cancer was not made by pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.

HEART ATTACK CLAIMS:

Submit electrocardiogram (EKG) or echocardiogram (ECG) results, cardiac enzyme (troponin) lab results, if available any cardiac catheterization report, the admission and discharge summaries of your hospital confinement.

STROKE CLAIMS:

Submit the Computer Axial Tomograph (CAT scan), a Magnetic Resonance Imaging (MRI) and/or Magnetic Resonance Angiography (MRA) results, the admission and discharge summaries or your hospital confinement if hospitalized, any speech, occupational or physical therapy evaluation notes.

INTENSIVE CARE (ICU) CLAIMS:

Submit a copy of your itemized hospital bill showing charges and the number of days in the intensive care unit (balance due statements). Other insurance carrier explanation of benefits statement(s) are not acceptable.

TRANSPLANT CLAIMS:

Please submit medical records of the transplant and a copy of the bill for transplant.

CRITICAL ACCIDENT CLAIMS:

Submit a copy of the emergency room report, itemized bill, and surgeon's bill if surgery was performed.

CLAIMS FOR DECEASED INSURED:

Please submit a copy of the Death Certificate, Power of Attorney and Estate Documents.

IF YOUR CLAIM IS RELATED TO AN ACCIDENT, PLEASE COMPLETE SECTION BELOW

Date of accident: _____ Time of accident: _____ AM _____ PM

What type of injury did you sustain: _____

Was this a work related accident/injury? ☐ Yes ☐ No

Was this an accident while playing in an Intercollegiate or Professional Sport? ☐ Yes ☐ No

If yes, please indicate type of sport: _____

Description of accident:

_____

_____

_____

Where accident occurred: City _____ State _____

Location: _____

Please provide the name, address and telephone number of physician(s) who treated you:

_____

Physician name, address and phone number

Is Medicaid involved in the coverage of your care, or medical expenses? ☐ Yes ☐ No

<u>If yes</u> and Medicaid is involved in the coverage of my expenses, I HERBY AUTHORIZE Guarantee Trust Life Insurance Company to coordinate benefits related to my bills in connection with this claim directly with the Hospital or Medical Provider. I understand that I am financially responsible for any charges not covered by the policy.

In addition, I understand that this claim form 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 the authorization upon request.

Insured Member Signature **Print Name:** **Date:**

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

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 or my authorized representative is 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 my 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 process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

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.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

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

Signature of Patient _____ 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 _____ 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.*

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.