TRANSAMERICA

Supplemental Health
SELF-ADMIN

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

Fax Number: 855-604-5205

Instructions for Submitting a Claim

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") – you cannot sign 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. Please contact our Contact Center at (855) 244-8318 for a copy of your certificate benefits to help determine what else you may need to submit to us for consideration.

Accident/Disability*
Claimant's Statement, Attending Physician's Statement (unless applying for accident medical expense benefits), HIPAA Authorization, Employer's/Business Entity's Statement, statement(s) showing actual charges/expenses for medical treatment or diagnosis, and a police report if the disability is a result of a motor vehicle accident. If the disability began with an emergency room visit, please provide us with a copy of the discharge summary; if the disability was an on-the-job accident, provide us with a first report of the injury.

Critical Assistance*
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, diagnostic reports (a pathology report if cancer-related), discharge summary or other medical records indicating the condition and date of diagnosis.

Cancer*
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, along with a pathology report diagnosing cancer. Itemized provider statements with actual charges/expenses (**) incurred for the treatment.

Heart/Stroke**
Claimant's Statement, Attending Physician Statement, HIPAA Authorization, and all itemized hospital statements with actual charges/expenses incurred for the treatment.

Intensive Care/Hospital Indemnity
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, itemized hospital or UB04 statements, and ambulance statement if transported (ICU Coverage only).

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

P.O. Box 219 Cedar Rapids, IA 52406-0219
Fax Number: 855-604-5205
E-mail: SelfAdminClaims@Transamerica.com

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 What is the policy/certificate you're filing this claim under? It can be more than one, so check all that apply:

☐ Accident ☐ Critical Illness ☐ Cancer ☐ Hospital Indemnity

1. Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Employee Social Security Number

5a. Mailing Address	6. Phone Number
5b. Street Address	**7. Email Address**

8. Employer	9. Occupation	10. Work Phone Number
11. Patient's Full Name	**12. Date of Birth**	**13. Relationship to Insured**

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. Have you previously had this same or similar condition? ☐ Yes ☐ No If yes, give date:
3. When did symptoms first appear or accident occur? If an injury, explain fully how and where accident occurred.	4. Date first treated/diagnosed
5. Name and address of physician (list all physicians consulted)	
6. Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No Do you have other health insurance? ☐ Yes ☐ No If yes, what company?	
7. Have you been confined to a hospital for this condition? ☐Yes ☐No Admission date: Discharge Date:	8. Please give name and address of hospital.
9. Were you confined in an Intensive Care Unit during this hospital stay? ☐ Yes ☐ No If yes, for how many days?	10. If you had surgery, please give the name and address of the surgeon
11. If you were unable to work due to this condition, please give dates. From To	12. If you were restricted to light duty due to this condition, please give dates. From To
13. When do you expect to resume your usual duties?	14. Are you filing a Workers' Compensation claim? ☐ Yes ☐ No
15. If applying for waiver of premium, give dates of total disability. From To	16. Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? ☐ Yes ☐ No If yes, provide condition and date?_____.
17. Please give the name and address of the physician and/or hospital who treated you for this the condition in box 16.	

Please continue onto next page

If you are filing for disability benefits 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)

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Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
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Claims Fax: 855-604-5205
Claims Email: SelfAdminClaims@Transamerica.com
Claims Customer Service: 855-244-8318

ATTENDING PHYSICIAN'S STATEMENT

1. 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 If yes, what company? ☐ No	
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. Is this condition work related? ☐ Yes ☐ No
10. If the patient previously received medical treatment, please provide the physician's/hospital's name and address.			
11. If the claim is for pregnancy, please give due date and type of delivery.		12. Has the patient ever had the same or similar condition? ☐ Yes ☐ No (If yes, state when and describe)	
13. Describe any other disease or infirmity affecting present condition.		14. List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.)	
15. List the dates of treatment and the charges for each visit.		16. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.	
17. Is the patient still under your care for this condition? ☐ Yes ☐ No If discharged, please give date _____		18. If the patient has been referred to another physician, please give the name and address.	
19. Did you advise patient to cease work? ☐ Yes ☐ No If yes: From To		20. Please give dates of total disability for this condition. From To	
21. If the patient was released to light duty due to this condition, please give dates From To		22. 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?	
23. Has patient ever been treated for a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to this time? ☐ Yes ☐ No If yes, please advise when and name and address of doctor/hospital treating patient.			
24. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.			

Date	Physician's Name – Print	Signature	Degree	Phone Number ( )
Street address	City	State	Zip	Tax Identification Number

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If you are filing for disability 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. Employee 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 or **(Please attach a copy of job description):**			
11. Did disability occur on the job? ☐ Yes ☐ No			
12. Date employee/insured person returned to work: _____ ☐ Full Time ☐ Part Time ☐ Light Duty	13. If "Part Time", due to partial disability, provide earnings: Amount: _____ From/To Dates: _____		
14. Employee/Insured Person's status of employment after first day absent: ☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Other: _____			
15. Employee/Insured Person's **current** status of employment: ☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Effective: _____			
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 information to obtain or amend insurance coverage or to make a claim for the payment of 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®

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

P.O. Box 219 Cedar Rapids, IA 52406-0219

HIPAA Authorization for Release of Health- Related Information

SELF-ADMIN

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)