GTL | GUARANTEE TRUST LIFE

HOSPITAL INDEMNITY CLAIM FORM

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.
- ❒ The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission.
- ❒ Attach itemized bills to the claim form. For faster processing, ask your medical provider to print an itemized bill on a UB-04 form (for hospital expenses) or on a CMS 1500/HCFA form (for doctor's expenses).

An itemized bill is a statement that indicates:

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

- **Processing delays may result if you do not provide the above information.**

- ❒ Please send the completed claim form, signed authorization, and itemized bills to:

Guarantee Trust Life Insurance
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 803-1835
OR Email to: HIClaims@gtlic.com

- ❒ We suggest you make photocopies of any information sent for your own records.

- **If your policy has been in force less than two years,** a completed claim form, and signed authorization needs to be submitted with your itemized bill.
- **If your policy has been in force more than two years,** only a claim form needs to be completed for a claim involving an injury

NOTE: Your Policy may have a 6 Month 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 hospital and you have a balance still due, we will have to pay benefits directly to them; otherwise, benefits will be sent to you.

For assistance, please contact our Customer Service Department (800) 338-7452

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HOSPITAL INDEMNITY CLAIM FORM

TO BE COMPLETED BY THE INSURED

Policy Number(s)

Name of Insured

Name of Patient Alternate Name

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

Phone **Email (Please provide for faster service)**

Date patient became ill or date of accident

If an accident, how did it happen?

Did you or will you file a Workers' Compensation claim? ❒ Yes ❒ No

If yes, what is the employer's name and address?

Attending doctor's name, address and phone number

Family doctor's name, address and phone number

Other doctors seen during the last two years – please include their address and phone number
(if more space is needed, attach separate sheet)

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 the authorization upon request.

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

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

HIPAA 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.

Policy/Certificate # _____

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 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 my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company 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. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

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 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 _____

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 _____