TRANSAMERICA
WORKSITE MARKETING

HEALTH MULTIPURPOSE CLAIM FORM

INSTRUCTIONS FOR SUBMITTING A CLAIM

The form has three parts: the Claimant's Statement, Attending Physician's Statement and the Authorization for the Release of Medical Records. When completing the form, keep in mind you can prevent the potential of a delay by providing complete and accurate information. Please complete all answers on the **Claimant's Statement** that are applicable to your claim. If the claim is on your spouse or a dependent child over the age of 18, the Claimant (patient) needs to sign and date the Authorization for the Release of Medical Records. When you ask the doctor to complete the **Attending Physician's Statement**, verify that the questions are answered and that it is signed and dated. We understand your need for a timely benefit payment.

Below are some of the more common documents and bills that are needed when filing a claim for a given type of policy. The suggested documents are not comprehensive. Refer to your policy benefits to help determine what bills should be submitted for consideration.

If you need help when completing your claim form, have questions about what documents need to be submitted, or need claim forms in the future, our Claims Customer Service representatives can help you. Please call them Monday through Friday between 7:00 AM and 5:00 PM, Central Standard Time at **800-251-7254.**

Cancer & Specified Disease*:

Claimant's Statement, Attending Physician's Statement, pathology report diagnosing cancer, itemized hospital bills, surgery/anesthesia bills, attending physician bills, chemotherapy and radiation bills.

Intensive Care:

Claimant's Statement, Attending Physician's statement and the itemized hospital or UB92 bill along with the ambulance bill, if any.

Accident/Disability*:

Claimant's Statement, Attending Physician's Statement, emergency medical treatment bills (must include a diagnosis), and police report (if one was prepared). If filing for accident medical-expense benefits, the Attending Physician's Statement does not have to be completed.

Critical Assistance*:

Claimant's Statement, Attending Physician's Statement and diagnostic reports (pathology report for a cancer diagnosis) or medical records indicating the condition and the date it was diagnosed.

First Occurrence Cancer:

Claimant's Statement, Attending Physician's Statement and pathology report diagnosing cancer.

Heart & Stroke, Hospital Indemnity:

Claimant's statement, Attending Physician's statement, hospital bills, surgery bills, anesthesia bills and (for Heart & Stroke) attending physician's bills.

**For Wellness Screening Benefit, submit bills/medical records from the physician or hospital showing date and procedure performed. No claim form is necessary.*

Transamerica Worksite Marketing
P.O. Box 8043
Little Rock, AR 72203-8043
1-800-251-7254
7 a.m. – 5 p.m. CST
Fax: 866-586-6528

Health Multipurpose Claim Form

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			
1. Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Social Security Number
5. Address (*include city, state and zip code)*			6. Phone Number
7. Employer	8. Occupation		9. Work Phone Number
10. Patient's Full Name	11. Date of Birth		12. 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. When have you had this same or similar condition?
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. What other health insurance do you have? (list all companies)	
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 date 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 so, when?
17. Please give the name and address of the physician and/or hospital who treated you for this previous condition.	

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WARNING: 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 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.

The information above is true and correct to the best of my knowledge.

Claimant's Signature: _____ Date: _____

ATTENDING PHYSICIAN STATEMENT

1. Insured	2. Policy Number
3. Name of Patient	4. Age of Patient

5. Other Insurance, including Medicaid	6. When did symptoms first appear or accident happen?
7. When did the patient first consult you for this condition?	8. Is this condition work related? ❒ Yes ❒ No

9. If the patient previously had medical attention, please provide the physician's/hospital's name and address.

10. If the claim is for pregnancy, please give due date.	11. Has the patient ever had the same or similar condition? ☐ Yes ☐ No (If yes, state when and describe)
12. Describe any other disease or infirmity affecting present condition.	13. List surgical procedure(s), if any, and include the date of the procedure(s) and the charges. (Please use current CPT codes.)
14. List the dates of treatment and the charges for each visit.	15. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.

16. Give number of days of ICU confinement.	17. Was Private Duty Nursing required and authorized by you? ☐ Yes ☐ No If yes, give dates.
18. Is the patient still under your care for this condition? ☐ Yes ☐ No If discharged, please give date _____	19. If the patient has been referred to another physician, please give the name and address.
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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Name of Insurance Company (select one):

- ❑ Transamerica Assurance Company
- ❑ Transamerica Life Insurance Company
- ❑ Transamerica Occidental Life Insurance Company
- ❑ Monumental Life Insurance Company
- ❑ Life Investors Insurance Company of America

If no Company is selected, the appropriate box will be checked by at the Administrative Office.

Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.

2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.

3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**

4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.

Patient/Insured's Name/Signature:		Patient/ Insured's SSN	
Personal Representative's (if any) Name/Signature:		Patient/ Insured's Date of Birth	
Patient/Insured's Address:		Effective Date	
Personal Representative's (if any) Address		Personal Representative's Phone Number	
Description of Personal Representative's Authority or Relationship to Patient/Insured			