

# **NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM**

## **INSTRUCTIONS FOR FILLING OUT A DISABILITY CLAIM FORM**

### **NOTE TO MEMBERS**

Our objective at Guarantee Trust Life Insurance Company is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service.

### **WHEN TO FILE A CLAIM**

1. Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

### **HOW TO FILE A CLAIM**

#### **Members Responsibility:**

1. All questions must be answered in full by the Member in order for us to process the claim.
  - It is very important that the name of Group or Association be indicated on claim form.
2. Employers portion of claim form must be completed and signed.
3. Attending Physician's Statement on claim form must be completed and signed.
4. The "Authorization To Permit Use and Disclosure of Health Information" must be signed and returned **with** the claim form.

**IMPORTANT:** Incomplete forms will result in a processing delay of your claim.

Also, please note that in furnishing this or other claim forms for the convenience of the member, GUARANTEE TRUST LIFE INSURANCE COMPANY does not admit any liability or waive any rights. GUARANTEE TRUST LIFE INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary by GUARANTEE TRUST LIFE INSURANCE COMPANY. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

### **WHERE TO FILE A CLAIM**

Send all completed forms to:

Guarantee Trust Life Insurance Company  
PO Box 1148  
Glenview, IL 60025

*If you have any questions, please contact our Customer Service Department at (800)622-1993.*



**Guarantee Trust Life Insurance Company**  
 P.O. Box 1148 • Glenview, IL 60025  
 Claims Department Phone Number: 800-622-1993 • FAX: 847-803-1835

**ACCIDENT DISABILITY CLAIM FORM**

**STATEMENT OF MEMBER**

Group or Association Name: \_\_\_\_\_ Member #: \_\_\_\_\_  
 Member Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Alternate Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 (Street) (City) (State) (Zip Code)  
 Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male  Female   
 Occupation: \_\_\_\_\_ Normal weekly hours: \_\_\_\_\_  
 Describe duties: \_\_\_\_\_

1. Date accident occurred: \_\_\_\_/\_\_\_\_/\_\_\_\_ 1a. Explain fully how and where accident occurred: \_\_\_\_\_
2. Did this accident occur while playing in an Intercollegiate Club or Organized Sport? Yes  No
3. Date of first medical attention: \_\_\_\_/\_\_\_\_/\_\_\_\_ 4. Physician's name and address: \_\_\_\_\_
4. Total Disability (unable to do any work) From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Partial Disability From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Give names of all physicians and hospitals who treated you for this injury causing the disability:  
 Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_
6. If you have not resumed work, what is your expected return date? : \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Do you have Disability Insurance with any other organization or entity? Yes  No
- 7a. If yes, give name and amount of disability benefits of each: \_\_\_\_\_
8. Are you claiming under any Workers' Compensation or other Employer's Liability Law? Yes  No
- 8a. If yes, give name and address of insurance company or other entity to which claim is made: \_\_\_\_\_
- 8b. If no, why not? \_\_\_\_\_

**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 this authorization upon request.**

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**BE SURE TO SIGN ABOVE & SECURE COMPLETED STATEMENT OF EMPLOYER & ATTENDING PHYSICIAN**

**STATEMENT OF EMPLOYER**

Employee's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. Date Employed: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 1a. Was Employee in your active employment when disability began? Yes  No
- 1b. If no, please explain: \_\_\_\_\_
2. Occupation: \_\_\_\_\_ 2a. Normal weekly hours: \_\_\_\_\_
3. Did accident happen on the job? Yes  No
4. Date last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date resumed work: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Is Employee totally disabled (unable to do any work)? Yes  No
6. If still disabled, when is Employee expected to return to work? : \_\_\_\_\_
7. Is claim being made under any Workers' Compensation or other Employer's Liability Law? Yes  No
- 7a. If yes, give name and address of company to which claim is made: \_\_\_\_\_

**Employer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. Diagnosis (describe nature of illness or injury): \_\_\_\_\_

2. Is condition the result of: Illness  Accident

2a. What date did accident occur?: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. If injury, how do you understand accident occurred?: \_\_\_\_\_

4. Has the patient had treatment for the same or related condition before?: Yes  No

4a. If yes, when and by whom? : \_\_\_\_\_

5. On what date were you first consulted for this condition? : \_\_\_\_/\_\_\_\_/\_\_\_\_

5a. Give dates of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

6. If hospitalized, give name and address of hospital and dates of confinement:

Name	Address	Dates - From/To

7. Was this Patient referred from another Physician? Yes  No

If yes, give name and address: \_\_\_\_\_

Name	Address	City	State	Zip

8. If surgery performed, please describe: \_\_\_\_\_

9. Total Disability (unable to do any work) From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Partial Disability From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

10. Prognosis: \_\_\_\_\_

11. If still disabled, when do you expect patient will be able to resume any work? : \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize GUARANTEE TRUST LIFE INSURANCE COMPANY or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to: \_\_\_\_\_

Signed: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Social Security or Tax ID No.: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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.

Alabama  
Arkansas  
California  
Connecticut  
Georgia  
Iowa  
Illinois

Kansas  
Louisiana  
Massachusetts  
Michigan  
Missouri  
Mississippi  
Montana

North Carolina  
North Dakota  
Nebraska  
Nevada  
Puerto Rico  
Rhode Island  
South Carolina

South Dakota  
Texas  
Utah  
Vermont  
Wisconsin  
West Virginia  
Wyoming

**Generic 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.

**Alaska, Delaware, Idaho, Indiana, Oklahoma** - 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.

**Colorado, Washington D.C., Hawaii, Maine, Tennessee, Virginia** - 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 coverage.

**Arizona, Minnesota, New Jersey, New Mexico** - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

**Kentucky, Ohio, Oregon** - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

**Florida** - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

**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.

**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.

**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.

**Rhode Island** - 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.

**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.

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
1275 Milwaukee Avenue, 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 is valid from the date signed for the duration of the claim.

\_\_\_\_\_  
(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