GTL | GUARANTEE TRUST LIFE

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

Please read the important information below:

- ☐ **If you have a Precision Care™ or Precision Medicine Product, you will need to use the specific Precision Care™ claim forms provided on the website.**
- ☐ 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 you medical provider(s) on your behalf if additional medical documentation is required in reviewing your claim. Please note, sometimes certain medical providers will not accept GTL's HIPAA Authorization and will require their own Special Release Authorization to be completed. If this should happen, we will advise you.
- ☐ We ask that you please do not submit copies of other insurance carriers Explanation of Benefits 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. If they are submitted, it can result in the rejection and/or delay of your claim.
- ☐ For your records, we suggest you make copies of any information you send us.
- ☐ Please send the completed claim form, signed HIPAA Authorization, and itemized bills to:

Guarantee Trust Life Insurance Company
P.O. Box 1145
Glenview, Illinois 60025
OR Fax to: (847) 904-5723
OR Email to: CHSClaims@gtlic.com

- ☐ **Please see page 3 on how to file your claim.**
- ☐ Should you have any questions, please call our Customer Service Department at **(800) 338-7452**. Our friendly, knowledgeable staff will be happy to answer your questions and provide you with any additional information you may need.

You can also go online to update your policy information at **www.gtlic.com** (click on Policy Login).

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

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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

*If filing for Precision Care™/Medicine Benefits, use specific Precision Claim form packets on website.

- ❐ 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
- ❐ Transportation Benefit
- ❐ Experimental Treatment
- ❐ Critical Accident ("Accident" questions, 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 ______

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

Date of accident: ____ / ____ / ____ Time of accident: ____ AM ____ PM

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:

____

____

____

____

Accident occurrence: City ____ State ____

Location: ____

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

____

Physician name, address and phone number

HOW TO FILE YOUR CLAIM 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.

TRANSPORTATION BENEFIT:

For treatment transportation, submit the actual bill for any expenses, such as cab, Uber, or other services. It should show service provider’s name, travel locations, dates of travel and cost. If you are filing for your own personal expense, submit a statement from your provider with the date/s of treatment, address of treating location, along with the address you are traveling from. On all claim filings, please indicate “Transportation Benefit” so we are sure to know what the bill is intended for. Mileage will be determined from the information you provide and the most direct route to locations.

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.

PLEASE BE ADVISED THAT IF THE ABOVE INFORMATION (PROOF OF DIAGNOSIS) IS NOT INITIALLY ACCOMPANIED WITH YOUR CLAIM FORM SUBMISSION, IT CAN DELAY THE REVIEW AND PROCESSING OF YOUR CLAIM.

YOUR POLICY MAY HAVE A PRE-EXISTING CONDITION(S) LIMITATION AND A 2 YEAR POLICY CONTESTABILITY PERIOD. THEREFORE, IF YOU WERE DIAGNOSED WITHIN TWO (2) YEARS OF YOUR POLICY EFFECTIVE DATE, IT IS SOMETIMES NECESSARY TO OBTAIN ADDITIONAL MEDICAL DOCUMENTATION FROM YOUR MEDICAL PROVIDERS. IF THIS SHOULD HAPPEN, WE WILL TRY TO ASSIST AS MUCH AS POSSIBLE IN CLARIFYING WHAT IS NEEDED AND EXPLAINING IF THERE ARE ANY DELAYS.

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 1145, Glenview, Illinois 60025
(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

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	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

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.