GTL | GUARANTEE TRUST LIFE

PRECISION CARE™ CANCER INSURANCE 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. If the claim is for a dependent child under the age of 18, the claim form and authorization must be signed by the Insured.
- ☐ The HIPAA Authorization to Permit Use and Disclosure of Health Information for your cancer coverage must be signed, dated and included with your claim submission, so that we can contact your 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 HIPPA Authorization and will require their own Authorization be signed. If this should happen, you will be contacted for the additional form.
- ☐ 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 process your claim and will cause delay of your claim.
- ☐ Please send the completed claim form, signed HIPAA Authorization, and itemized bills to:

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

- ☐ **If you will be utilizing your TGen Precision Medicine Rider, there are additional instructions and forms provided that need to be completed and submitted to start the process for your Precision Medicine coordination.**
- ☐ For your records, we suggest you make copies of any information you send us.
- ☐ Should you have and questions, please call our Customer Service Department at **(800) 338-7452.** Our friendly, knowledgeable staff will be happy to answer you 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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Mail claims to:
P.O. Box 1145
Glenview, Illinois 60025
Or fax to: (847) 904-5723
Or email to: CHSClaims@gtlic.com
For Customer Service, please call: (800) 338-7452

PRECISION CARE™ CANCER 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 CLAIM IS BEING FILED

- ☐ Cancer (malignant melanoma/adenocarcinoma)
- ☐ Advanced Stage Cancer (Stage III or IV)
- ☐ Cancer In Situ (Stage 0 or early stage cancer)
- ☐ Skin Cancer (Basal Cell Carcinoma or Squamous Cell Carcinoma)
- ☐ TGen Precision Medicine Rider
- ☐ Return of Premium
- ☐ Transplant
- ☐ Experimental Treatment

INSTRUCTIONS FOR FILING CLAIM:

CANCER OR SKIN CANCER CLAIM:
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 the pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.

PRECISION MEDICINE:
To begin the process for your genomic sequencing and Precision Medicine benefits, you need to first file for your cancer benefits and complete the additional Precision Medicine forms and submit both to us.

TRANSPLANT CLAIMS:
Please submit medical records of the transplant and a copy of the bill for the transplant.

CLAIM FOR DECEASED INSURED:
Please submit a copy of the Death Certificate, Power of Attorney, and Estate Documents.

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:

_____
Name Address Telephone Number

Oncologists name, address and telephone number:

_____
Name Address Telephone Number

If there were 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:

_____
Name Address Telephone Number

If there were any other physicians seen during the last two (2) years (if more space is needed, attach separate sheet)
If so, please provide their names, addresses and telephone numbers:

_____
Physician Name Address Telephone Number

_____
Physician Name Address Telephone Number

_____
Physician Name Address Telephone Number

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
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 _____

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

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.

GTL | GUARANTEE TRUST LIFE

tgen® AN AFFILIATE OF City of Hope

Your GTL Precision Care™ Cancer Insurance Coverage includes access to genome sequencing by TGen, The Translational Genomics Research Institute.

In the event you are diagnosed with cancer, please complete and submit a claim form to GTL and provide the information below to your physician.

WHO IS TGEN?

The Translational Genomics Research Institute (TGen), an affiliate of City of Hope, is a leading nonprofit biomedical research institute for developing and applying genomics technologies to individualize treatment, working closely with expert physicians.

TGen's internationally-recognized cancer physicians and researchers are innovators in clinical genomic testing and pioneers in precision medicine.

TGen physicians will work one-on-one with you and your patient to interpret test results and review appropriate treatment options.

WHY GENOME SEQUENCING FROM TGEN?

TGen's genomic sequencing looks at **19,000** genes vs average of 400 genes for competitors.

TGen is **known throughout the country** for their **ground-breaking research** and **advanced technology.**

TGen provides you and your patient with **one-on-one consultations** to explain their sequencing results and treatment options.

NEXT STEPS FOR PHYSICIANS

A TGen representative will contact your office to coordinate and schedule your patient's genomic sequencing order.

Once the sequencing is complete, a TGen cancer expert will contact you and your patient to go over the results and provide treatment recommendations based on specific markers found in your patient's DNA.

If you have any general questions, please call Guarantee Trust Life Insurance Company's Customer Service at **800-338-7452**.

Please visit **www.OutsmartMyCancer.com** for more information.

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PRECISION MEDICINE BENEFIT CLAIM FORM

Please read the important information below:

☐ If **you are** filing to utilize your Precision Medicine benefits, it is critical that **all** forms provided here are completed, signed, dated, and returned.

☐ If **you are not** filing to utilize your Precision Medicine benefits or coordination services, you do not need to complete these forms.

☐ Please be sure your policy number(s) is/are written on all documents.

☐ The claim form must be completed and signed by the Insured. If the claim is for a dependent child under the age of 18, the claim form and authorization must be signed by the Insured.

☐ The following forms are provided and must be completed and returned in order to process your claim:

- **Precision Medicine** claim form and request to begin process for coordinating your genomic sequencing.
- **Special HIPAA Authorization** allowing our partner, TGen, to contact your doctor and begin coordinating your genomic sequencing. Although you may have already signed a HIPAA Authorization for you cancer claim, this Special Authorization is needed for TGen to conduct and work directly with your doctor.
- If you will be using our partner, TGen, to actually perform your genomic sequencing, there is a required **Assignment of Benefits** form to be signed. This allows GTL to provide benefits directly to TGen to cover the expenses of your sequencing.

☐ Please note that your Precision Medicine rider does contain a Waiting Period to be satisfied.

☐ For your records, we suggest you make copies of any information you send us.

☐ If you and your doctor will not be utilizing TGen to coordinate and perform your genomic sequencing, you can still use another qualified independent lab to do so and qualify for benefits. Please check the box on the Assignment of Benefits form that you are declining services through TGen.

If using a qualified independent lab for your genomic sequencing, we will need an invoice from the lab reflecting the actual test performed and the cost. We do not request or review actual test results.

☐ **IMPORTANT: Your cancer claim must be filed with us and determined to be payable under your base cancer coverage before benefits can be provided on your Precision Medicine rider.**

The provided forms should be completed and submitted to start the coordination process, but the benefits cannot be provided for the expense until base cancer benefits are determined payable.

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

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

☐ 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).

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or email to: CHSClaims@gtlic.com
For Customer Service, please call: (800) 338-7452

PRECISION MEDICINE BENEFIT CLAIM FORM

TO BE COMPLETED BY THE INSURED

Policy Number(s) Name of Primary Insured

Claimant/Patient Name receiving test Date of Birth

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

Phone Email

Name of your Oncologist coordinating your care: _____

Address: _____ Phone Number: _____

Name of your Oncologists Assistant we can contact: _____ Phone Number: _____

☐ I **will** be using TGen to coordinate my testing	☐ I **will not** be using TGen to coordinate my testing
NEXT STEPS: • GTL will be reviewing and processing your cancer claim for benefits. • You have chosen to utilize TGen to coordinate and preform your genomic sequencing. TGen will make contact with your Oncologist directly and begin the exchange of information and coordination of the tissue sample to be tested. • The actual genomic sequencing can begin as soon as you, your doctor and TGen agree. Please remember that the benefits to cover the cost of this test cannot be considered until your claim on the base cancer coverage has been determined payable.	NEXT STEPS: • GTL will be reviewing and processing your cancer claim for benefits. • You have chosen to not utilize TGen, but to instead choose your own lab or one of your doctor's choice. Therefore there will be no coordination for consultation or any exchange of information to GTL and TGen to coordinate the genomic sequencing. • Once your tests have been completed and you receive a bill, please submit that to GTL for consideration. • Please remember that the benefits to cover the costs of this test cannot be considered until your cancer claim on the base coverage is determined payable.

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 and information above is 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. I understand that the Precision Medicine benefits are not guaranteed until the base cancer claim has been determined to be payable.

Insured Member Signature **Date**

Guarantee Trust Life Insurance Company
P.O Box 1145, Glenview, Illinois 60025
1-800-338-7452

SPECIAL HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information Related to Diagnosed Cancer, Genomic Sequencing and / or Targeted Medical Treatment

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits as it relates to a diagnosis of cancer, genomic sequencing performed by a qualified laboratory provider and consultation between medical professionals regarding targeted cancer treatment options.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), the sharing of my protected health information with the Translational Genomics Research Institute (TGen)/Ashion, or other qualified laboratory provider, for the purpose of performing genomic sequencing. Further, I authorize TGen/Ashion, or other qualified laboratory provider, to discuss the results of such genomic sequencing with my physician and other medical professionals for the express purpose of identifying and recommending a course of targeted cancer treatment based on the results of my genomic sequencing. 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 _____

Guarantee Trust Life Insurance Company
P.O Box 1145, Glenview, Illinois 60025
1-800-338-7452

ASSIGNMENT OF BENEFITS

☐ **Yes, I would like TGen to handle the coordination and perform my genomic testing.**
If yes, please sign, date and return this form to us.

☐ No, I will not be utilizing TGen to handle the coordination and perform my genomic sequencing or utilize their expert consulting services on my test results and treatment options with my oncologist. Before making this choice, be aware other qualified laboratories may charge more than benefits in your plan resulting in out-of-pocket expenses to you.

Provider of Service:
TGen
ATTN: Ashion Analytics™
445 North 5th Street
Pheonix, AZ 85004

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan. I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility
I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)