GTL | GUARANTEE TRUST LIFE

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).

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

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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), or other qualified laboratory provider, for the purpose of performing genomic sequencing. Further, I authorize TGen, 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)