

**PRESCRIPTION DRUG CLAIM FILING FORM  
for your SHORT-TERM HOME HEALTH CARE COVERAGE**

**Please read the important information below:**

- This form is used only for filing for **Prescription Drug benefits**.
- Please be sure your policy number(s) is/are written on all Prescription Drug documents.
- A full completed claim form is NOT required for Prescription Drug benefits. Just use this Prescription Drug Filing Form to properly route your claim.
- IF you are filing a claim, or submitting bills OTHER than prescription drugs at this time, please be sure to access the appropriate claim form package from our website, or contact us directly.
- Proof of Prescription Drugs should be attached to this filing form. Proof would consist of:
  - **Claimants name**
  - **Name of medication**
  - **Date medication was filled**
  - **Medication RX number**
  - **Pharmacy name**

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

**Guarantee Trust Life Insurance**  
**P.O. Box 1144**  
**Glenview, Illinois 60025**  
**OR Fax to: (847) 904-5723**

- Please note:** Even though we are providing Prescription Drug benefits, your policy may still be in the pre-existing or two year contestable period for any Short Term Home Health Care benefit consideration.
- We suggest you make copies of any information sent to us for your records.
- Should have any questions, please call our Customer Service Department at (800) 622-1993. Our friendly, knowledgeable staff will be happy to assist you.

Policy Number(s) for Prescription Drug	Policyholder's Name
RX Claimant/Patient Name #1	Date of Birth
RX Claimant/Patient Name #2 (If any)	Date of Birth
Address (Street)	(Zip)
Phone	Email

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