GTL | GUARANTEE TRUST LIFE

How-To Video
Scan with your phone to watch a quick guide on to file your claim.

HOSPITAL INDEMNITY 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 your policy has been in force less than two years from when your claim was incurred,** the policy is still in the Contestable Period and a completed claim form, plus a completed and signed HIPAA Authorization, as well as any hospital bills are required for the filing of your claim.
- 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 your medical provider on your behalf if additional information is needed.
- **If your policy has been in force more than two years from when your claim was incurred,** a claim form is not required and you can just submit the related bills for consideration.

☐ For faster processing of your hospital benefits, **ask the hospital for a billing summary ON a UB-04 form.**

A UB-04 form are statements that indicate:

1. The date(s) of treatment,
2. The type(s) of service and individual charges,
3. The diagnosis being treated,
4. The provider's name and address

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

Guarantee Trust Life Insurance
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 699-1048
OR Email to: Claims@gtlic.com

☐ If you were detained overnight within a hospital setting, but not actually inpatient confined, we will need the hospital bill reflecting the ADMIT and DISCHARGE times as well as the dates to see if any benefits may be due.

☐ If you have special benefits **Riders** on your policy, such as Cancer Lump Sum, Surgery, or Physical Therapy, we may require additional information beyond the claim form and bills. If we do you will be notified.

☐ If you signed an "Assignment of Benefits" with the provider and you have a balance due, benefits will be paid to the provider; otherwise, benefits will be paid to you.

☐ **NOTE:** Your Policy may have a Pre-Existing Period and a 2-year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required and we will handle these requests directly with your provider as long as we have the signed HIPAA Authorization. We will notify you of our actions and any delays.

- **Processing delays may result if you do not provide the requested information.**

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

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HOSPITAL INDEMNITY CLAIM FORM

COMPLETED BY THE INSURED

Name of Insured _____ Policy Number(s) _____

Name of Patient _____ Alternate Name _____

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

Phone _____ **Email (Please provide for faster service)** _____

COMPLETED ON PATIENT

What condition is causing this claim? _____

Date patient first became ill: ___/___/___

Were you hospitalized for this condition? ☐ Yes ☐ No

If yes, please provide the name and location of hospital: _____

What were the dates of hospitalization: ___/___/___ to ___/___/___

Were you admitted through the Emergency Room? ☐ Yes ☐ No Was any type of surgery required? ☐ Yes ☐ No

Date patient first saw doctor for this condition? ___/___/___

Did you or will you file a Workers' Compensation claim? ☐ Yes ☐ No

Treating doctor's name, address and phone number: _____

_____

Family doctor's name, address and phone number: _____

_____

Were there any other doctors seen during the last two (2) years ? If so, please include their names, addresses and phone numbers.
If more space is needed, please attach separate sheet.

Is Medicaid involved in the coverage of your care, or medical expenses? ☐ Yes ☐ No

<u>If yes</u> and Medicaid is involved in the coverage of my expenses, I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to coordinate benefits related to my bills directly with the Hospital or Medical Provider. I understand that I am financially responsible for any charges not covered by the policy.

In addition, I understand that this claim form 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 1144, Glenview, Illinois 60025
1-800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy/Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. 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. 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 GTL, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent GTL 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.

I understand that GTL 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. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

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.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(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.*

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.