Transamerica Worksite Marketing
P.O. Box 8043
Little Rock, AR 72203-8043
Phone: 800-251-7254 (7:00 a.m. – 5:00 p.m. CST)
Fax: 866-586-6528

# Disability Benefit Claim Form

## Instructions to submit claim

1) The insured must complete the Claimant's Statement and must sign and date the *Authorization for the Release of Health Information* and *Fraud Warning Statement*. We need this authorization to obtain additional claim information and provide prompt claim service.

2) Have your Employer complete the Employer's/Business Entity's Statement, answering all questions in full.

3) Have your physician complete the Attending Physician's Statement, answering all questions in full.

4) If disability is a result of a motor vehicle accident, please submit a copy of the police report.

5) If disability began with an Emergency Room visit, please submit a copy of the Discharge Summary.

6) Fax the completed forms to 1-866-586-6528, or mail to the address shown on the claim form.

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# Disability Benefit Claim Form

## Claimant's Statement

| 1. Full Name: | 2. Date of Birth: | 3. Certificate Number: | 4. Home Phone: |
|---|---|---|---|

| 5. Street Address: | 6. City: | 7. State: | 8. Zip Code: |
|---|---|---|---|

9. Date Accident or Illness began:

10. Is this disability due to:
☐ Motor Vehicle Accident ☐ Other Accident or Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy

11. Please describe your medical condition(s) or injury that is resulting in your disability. If related to an accident or injury, advise when, where and how the accident or injury occurred. ____________________

12. Have you been confined to a hospital for this condition? ☐ Yes ☐ No
If "Yes", admitted: discharged:

13. Have you ever had or been treated for the same or similar condition? ☐ Yes ☐ No If "Yes", when and please describe.

____________________
____________________
____________________

14. Name and address of hospital(s):

| Name | Address | City | State | Zip |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

15. Name and address of doctor(s):

| Name | Address | City | State | Zip |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

16. Last date worked:

17. Date returned to work:
☐ Full Time ☐ Part Time

18. If not returned, date anticipated to return:

19. Are you currently employed by another employer? ☐ Yes ☐ No If "Yes", when and please provide the name and telephone number of that employer.

To the best of your knowledge, indicate if you have filed for or are receiving income from any of the following sources:

Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked ____________
EIB/PTO ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked____________

| | Applied for | Receiving | Amount | Frequency | From/To Dates |
|---|---|---|---|---|---|
| Short Term Disability | ☐ | ☐ | $______ | ______ | ______/______ |
| Worker's Compensation | ☐ | ☐ | $______ | ______ | ______/______ |
| State Disability | ☐ | ☐ | $______ | ______ | ______/______ |
| Social Security | ☐ | ☐ | $______ | ______ | ______/______ |
| Dependent Social Security | ☐ | ☐ | $______ | ______ | ______/______ |
| No Fault (Income Replacement) | ☐ | ☐ | $______ | ______ | ______/______ |
| Retirement/Pension | ☐ | ☐ | $______ | ______ | ______/______ |
| Permanent Total Disability | ☐ | ☐ | $______ | ______ | ______/______ |
| Other (Please identify) ____________ | ☐ | ☐ | $______ | ______ | ______/______ |

The information above is true and correct to the best of my knowledge.

Claimant's Signature: ______________________________ Date: ____________________

Transamerica Life Insurance Company
Transamerica Occidental Life Insurance Company
Life Investors Insurance Company of America
Monumental Life Insurance Company

## Employer's/Business Entity's Statement

1. Company Name:

2. Phone Number:

3. Street Address:

4. City:

5. State:

6. Zip Code:

7. Name of Employee:

8. Social Security #:

9. Was Employee covered by the previous carrier? ☐ Yes ☐ No If "Yes", Effective date: ____________ Benefit amount: ______________

10. Employee's job title/major job duties (**Please attach a copy of employee's job description**):

11. Job Classification:
☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

12. Annual Salary:

13. Average hours worked per week:

14. Does this employee contribute to Social Security? ☐ Yes ☐ No
If "No", was the employee hired after 4/1/86? ☐ Yes ☐ No

15. Is the disability premium paid by the employee? ☐ Yes ☐ No
If "Yes", ☐ Before or ☐ After taxes

16. Percentage of the employee's disability premium you pay:

17. Is this disability a result of employment? ☐ Yes ☐ No

18. Date employee last worked:

19. Employee's status as of first day absent:
☐ Active ☐ Vacation ☐ Leave of Absence ☐ Laid Off ☐ Terminated ☐ Retired
If other than Active, Please explain:______________________________________________

20. Date employee returned to work: ______________
☐ Full Time ☐ Light Duty ☐ Part Time

21. If "Part Time", due to partial disability, provide earnings:
Amount: ______________ From/To Dates: __________________

22. To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the following sources:

Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked ______________
EIB/PTO ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked______________

| | Applied for | Receiving | Amount | Frequency | From/To Dates |
|---|---|---|---|---|---|
| Short Term Disability | ☐ | ☐ | $________ | ________ | ________/________ |
| Worker's Compensation | ☐ | ☐ | $________ | ________ | ________/________ |
| State Disability | ☐ | ☐ | $________ | ________ | ________/________ |
| Social Security | ☐ | ☐ | $________ | ________ | ________/________ |
| Dependent Social Security | ☐ | ☐ | $________ | ________ | ________/________ |
| No Fault (Income Replacement) | ☐ | ☐ | $________ | ________ | ________/________ |
| Retirement/Pension | ☐ | ☐ | $________ | ________ | ________/________ |
| Permanent Total Disability | ☐ | ☐ | $________ | ________ | ________/________ |
| Other (Please identify) ______________ | ☐ | ☐ | $________ | ________ | ________/________ |

23. Will employee earn any future Salary Continuance/Sick Leave/EIB/PTO? ☐ Yes ☐ No If "Yes", please indicate date: ________________

24. Employee/Insured Person's current status of employment:
☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Effective: ___________________

The above statements are true and complete to the best of my knowledge and belief.

Employer's Authorized Representative

Name (please print) ________________________________ Title ____________________________ Phone # ______________

Signature ________________________________________ Date ______________________

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## Attending Physician's Statement

| Patient Name: | Date of Birth: | Social Security No.: |
|---|---|---|

Instructions: The following sections must be completed and signed by the attending physician.
**Please complete all applicable sections of this form. In all situations, you must complete the signature block at the bottom of this form.**

### Normal Pregnancy

| a) Expected Delivery Date: ______________<br>Date first unable to work: ______________ | b) Actual Delivery Date: ______________<br>Date Hospitalized: ______________ | c) Delivery Type:<br>☐ Vaginal ☐ C-Section |
|---|---|---|

### All Other Conditions

1. Primary ICD-9: _________-_________ Diagnosis: ______________________________

   Secondary ICD-9: _________-_________ Diagnosis: ______________________________

2. Is condition due to injury or sickness arising out of patient's employment?
   ☐ Yes ☐ No ☐ Unknown

3. Date symptoms first appeared or accident happened:

4. Has patient ever had same or similar condition? ☐ Yes ☐ No
   If "Yes", when and describe: ______________________________

5. Is patient still under your care for this condition? ☐ Yes ☐ No
   Final date of treatment: ______________

6. Initial date of treatment: ______________ Most recent date of treatment: ______________

7. Frequency of follow-up: ☐ Weekly ☐ Monthly ☐ Other: ______________________________

8. Dates of services since disability commenced:
   ______________________________
   ______________________________
   ______________________________

9. Was patient hospitalized? ☐ Yes ☐ No
   Name of Hospital:
   Address:
   City: State: Zip:
   Admitted: Discharged:

10. Was surgery performed? ☐ Yes ☐ No If "Yes", CPT 4 code(s): ______________ Date surgery performed: ______________

11. Was the patient referred to you? ☐ Yes ☐ No If "Yes", give the referring physician's name and address.

    Physician's Name: ______________________________ Phone Number: ______________

    Address: ______________________________ City: ______________ State: ________ Zip: __________

12. Has patient reached a point of maximum medical improvement? ☐ Yes ☐ No

13. Did you advise patient to cease work? ☐ Yes ☐ No If "Yes", on what date: ______________

14. Have you advised patient to return to work?
    ☐ Yes, date of return: ______________ ☐ To regular occupation: ☐ Full Time ☐ Part time
    ☐ To any other occupation: ☐ Full Time ☐ Part time
    ☐ No, please explain: ______________________________

    Please describe any work/activity restrictions (please be specific): ______________________________

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The above statements are true and complete to the best of my knowledge and belief.

Physician's Name (please print) ______________________________ Degree: ______________

Address: ______________________________ City: ______________ State: ________ Zip: __________

Phone Number: ______________ Fax Number: ______________ Tax ID Number: ______________

Signature: ______________________________ Date: ______________

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## REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. 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.

Claimant's signature Date

FOR RESIDENTS OF 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 the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA: 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.

Claimant's signature Date

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Claimant's signature Date

FOR RESIDENTS OF LOUISIANA: 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.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

FOR RESIDENTS OF 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 by RSA 638:20.

Claimant's signature Date

FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF OKLAHOMA: 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.

Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than $5,000 dollars nor more than $10,000 dollars, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years.

Claimant's signature Date

FOR RESIDENTS OF VIRGINIA, TENNESSEE, MAINE, or DISTRICT OF COLUMBIA: 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.

Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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.

Claimant's signature Date

TRANSAMERICA
WORKSITE MARKETING

*Name of Insurance Company (select one):*

- ❑ Transamerica Life Insurance Company
- ❑ Transamerica Occidental Life Insurance Company
- ❑ Monumental Life Insurance Company
- ❑ Life Investors Insurance Company of America

If no Company is selected, the appropriate box will be checked by the Administrative Office.

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Administrative Office: P.O. Box 8043
Little Rock, Arkansas 72203-8043

## AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. <u>I also understand that the revocation of this authorization will not affect uses and disclosers of my health information for purposes of treatment, payment or health care operations.</u>
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature ______________________ Date ____________

Patient/Insured's SSN ____________ Patient/Insured's Date of Birth ____________ Patient/Insured's Phone No. ____________

Patient/Insured's Address ______________________

Personal Representative's (if any) Name/Signature: ____________ Personal Representative's Phone No. ____________

Personal Representative's (if any) Address ______________________

Description of Personal Representative's Authority or Relationship to Patient/Insured ______________________

Policy or Contract Number ______________________