NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT A SPECIAL ACCIDENT CLAIM FORM

- The claim form must be completed and signed by the Member. Please indicate your Group or Association name on the claim form. Also, the "Authorization To Permit Use and Disclosure of Health Information" must be signed.

- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Treatment Period".

- PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED **WITHIN 90 DAYS OF THE ACCIDENT**. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED **WITHIN 90 DAYS OF TREATMENT**.

- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
  1) **The date(s) of treatment,**
  2) **The type(s) of service,**
  3) **The diagnosis,**
  4) **The medical provider's name and address**
  5) **The individual charge for each expense**.

- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement. **Please note**: This is not necessary if you have purchased a "Primary" plan through GTL that pays regardless of other insurance payments.

- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

GUARANTEE TRUST LIFE INSURANCE COMPANY
P.O. Box 1148
Glenview, Illinois 60025

- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form.

- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.

- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please take note that your claim will result in a processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at (800) 622-1993.

G·T·L

Guarantee Trust Life Insurance Company • P.O. Box 1148 • Glenview, IL 60025
Group Claim Department Phone Number: 800-622-1993 • FAX: 847-803-1835
Email: Special_riskdiv@gtlic.com

ACCIDENTAL DISMEMBERMENT & LOSS OF SIGHT CLAIM FORM

TO BE COMPLETED BY INSURED MEMBER

Group or Association Name: United Family Association ACC164-165 series

Name of Insured Member: _____ Alternate Name: _____

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

Phone Number: (_____) _____ - _____ Insured Member Date of Birth: _____/_____/_____

Social Security Number/Member Identification Number: _____

Patient's Name and Relationship (If other than Insured Member): _____

Patient's Date of Birth: _____/_____/_____ Male ❑ Female ❑

1. Date of Accident: _____/_____/_____ 1a. Hour: _____:_____ AM ❑ PM ❑
2. Description of Accident:
   A) How did it occur? _____
   _____
   B) Where did it occur? City: _____ State: _____ Location: _____
   C) Nature of Injury? _____
   D) Due to this injury, were or are you currently totally disabled? Yes ❑ No ❑
3. Did this accident occur while playing in an Intercollegiate Club or Organized Sport? Yes ❑ No ❑
   If yes, please indicate the type of sport: _____
4. Was this a work related accident/injury? Yes ❑ No ❑ 4a. Are you self employed? Yes ❑ No ❑
4b. Was this filed with Workers' Compensation? Yes ❑ No ❑
4c. If no, please explain why: _____
5. Is the Patient covered by any other plan (including Workers' Compensation) for expenses related to this accident? Yes ❑ No ❑
5a. If yes, provide the following information of the Insurance Carrier:
   Insured/Member/Owner Name: _____
   Carrier Name: _____
   Address: _____
   (Street) (City) (State) (Zip Code)
   Phone Number: (_____) _____- _____ Policy Number: _____
   Effective Date: _____/_____/_____ Termination Date (if applicable): _____/_____/_____

PLEASE NOTE: Incomplete claim forms will result in process delay.

I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy.

_____ _____/_____/_____
Signature of Insured Member Date

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

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 this authorization upon request.

Insured Member Signature: _____ Print Name: _____ Date: ____/____/_____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient: _____ **Date of Birth:** _____/_____/_____

Date first consulted on injury described: _____/____/_____ **Date of last treatment:** _____/_____/_____

Describe the exact nature, location and extent of all injuries sustained: _____
_____

Which limb(s) were severed or amputated? _____

State the date(s) on which the severance(s) or amputation(s) occurred: _____/_____/_____ _____/_____/_____

State the exact point at which the amputation was performed or the severance occurred with respect to each limb loss. If the severance or amputation was below the elbow or knee joint, indicate the exact point of severance: _____
_____

State the cause of the amputation: _____

Did the patient ever consult you before? ❑ **Yes** ❑ **No** **If "Yes," please state dates and the ailments for which you attended, treated or examined.**
Dates: _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

Ailments: _____

Please give the names of other physicians that have attended this patient and the dates of their first and last treatments as reported to you: _____

TO BE COMPLETED *ONLY* FOR LOSS OF VISION

Give the date you first determined vision was irrevocably reduced to 20/200 (Snellen Notation) or less with correction and the vision remaining in each eye: _____/_____/_____

Snellen Notation

O.D.v. ❑ Uncorrected ❑ Corrected
O.S.v. ❑ Uncorrected ❑ Corrected

Give the date and vision found on last eye examination: _____/_____/_____

Snellen Notation

O.D.v. ❑ Uncorrected ❑ Corrected
O.S.v. ❑ Uncorrected ❑ Corrected

State the causes of loss of vision: _____

Indicate whether recovery of useful vision is possible by operation or treatment.
O.D. ❑ Operation ❑ Treatment
O.S. ❑ Operation ❑ Treatment
If fields of vision are contracted, please indicate the exact point of contraction: _____
_____

Was the injury described above solely responsible for the loss? ❑ **Yes** ❑ **No**
If "No," give the particulars of any contributing cause(s)? _____
_____

I hereby authorize GUARANTEE TRUST LIFE INSURANCE COMPANY or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to: -
_____

Signed: _____ Degree: _____ Date: _____/_____/_____

Address: _____
Street City State Zip Code

Social Security or Tax ID No.: _____-_____- _____ Phone Number: (_____) _____ - _____

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.

Alabama
Arkansas
California
Connecticut
Georgia
Iowa
Illinois
Kansas
Louisiana
Massachusetts
Maryland
Michigan
Missouri
Mississippi
Montana
North Carolina
North Dakota
Nebraska
Nevada
Puerto Rico
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
Wisconsin
West Virginia
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.

Alaska, Delaware, Idaho, Indiana, Oklahoma
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.

Colorado, D.C., Hawaii, Maine, Tennessee, Virginia
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 coverage.

Arizona, Minnesota, New Jersey, New Mexico
Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon
Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida
Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

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.

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.

Washington
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.

GUARANTEE TRUST LIFE INSURANCE COMPANY

PO Box 1148
Glenview, Illinois 60025
1-800-622-1993

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.

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 have the right to revoke this Authorization, in writing, at any time by sending written notification to us at the above address. I understand that a revocation will not be effective to the extent we have 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 or Human Resources.

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 is valid from the date signed for the duration of the claim.

_____
(Print Please) Name of Patient

_____
Signature of Patient and 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 and Date