TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company
Monumental Life Insurance Company

HEALTH MULTIPURPOSE CLAIM PACKAGE
Instructions for Submitting a Claim

The package has four parts: Claimant's Statement, Attending Physician's Statement, Required Fraud Warning Statements and Authorization for the Release of Health Information. When completing each part, keep in mind you can prevent the potential of a delay by providing complete and accurate information. Please complete all answers on the Claimant's Statement that are applicable to your claim. If the claim is on your dependent over the age of 18, the Claimant (patient) needs to sign and date the Authorization for the Release of Health Information. When you ask the doctor to complete the Attending Physician's Statement, verify that the questions are answered and that it is signed and dated. We understand your need for a timely benefit payment.

Below are some of the more common documents and statements that are needed when filing a claim for a given type of policy. The suggested documents are not comprehensive. Refer to your policy benefits to help determine what information should be submitted for consideration.

If you need help when completing any document, have questions about what documents need to be submitted, or need a Claim Package, our Claims Customer Service representatives can help you. Please call them Monday through Friday between 7:00 AM and 6:00 PM, Central Time at 800-251-7254.

Intensive Care**:
The four parts of the Claim Package and the itemized hospital or UB92 statement and, if an ambulance was used, a statement showing the actual charges/expenses incurred.

Accident/Disability*:
The four parts of the Claim Package and, if emergency medical treatment was received, a statement showing actual charges/expenses incurred with the diagnosis and a police report (if one was prepared). If filing for accident medical-expense benefits, Attending Physician's Statement is not required.

Critical Assistance*:
The four parts of the Claim Package and diagnostic reports (pathology report for a cancer diagnosis) or medical records indicating the condition and the date it was diagnosed.

First Occurrence Cancer:
The four parts of the Claim Package and a pathology report diagnosing cancer.

Heart & Stroke, Hospital Indemnity**:
The four parts of the Claim Package, itemized hospital statements, itemized surgery statements, itemized anesthesia statements and (for Heart & Stroke) itemized physician statements. These itemized statements should show the actual charges/expenses incurred for your treatment.

**For Wellness Screening Benefit, you only need to submit bills/statements/medical records from the physician or hospital showing date and procedure performed. No additional documents are necessary.*

***If you are covered by Medicare or Medicaid or other insurance, please submit statements from Doctor/ Medical Provider/Hospital showing payments or adjustments by Medicare, Medicaid or your other insurance. Also submit any other information showing the actual charges/expenses incurred for your treatment such as a copy of all Summary Notices from Medicare or Medicaid or Explanation of Benefits from your other insurance.*

Please return completed documents to the following address:

Transamerica Employee Benefits
P.O. Box 8043
Little Rock, AR 72203-8043

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Name of Insurance Company (select one):

☐ Transamerica Life Insurance Company
☐ Monumental Life Insurance Company

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

Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

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 or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- 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's/Insured's Name/Signature:	_____	Date	_____
Personal Representative's (if any) Name/Signature:	_____	Patient's/ Insured's SSN	_____
Patient's/Insured's Address:	_____	Patient's/ Insured's Date of Birth	_____
Personal Representative's (if any) Address	_____	Personal Representative's Phone Number	_____
Description of Personal Representative's Authority or Relationship to Patient/Insured	_____		
Policy or Contract Number	_____		

Claimants should retain a copy of this signed document for their records