NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the Organization **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). 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 policy 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 our payment to go directly to the medical provider, please notate this on the bills.

- 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.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

GUARANTEE TRUST LIFE INS. CO.
P.O. Box 1148
Glenview, IL 60025
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: _____ Hosp.: _____ Other: _____
Addr: _____ Addr: _____ Addr: _____
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE _____ **SIGNATURE OF PARENT OR GUARDIAN** _____
Claimant – if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. **Claimant's FULL NAME** _____ Alternate Name _____ Date of Birth ___/___/___ Grade _____

2. Claimant's Address: Street or RFD _____ City _____ State _____ Zip _____

3. Date of Accident _____ 20_____ Hour _____ AM ☐ PM ☐

4. Description of Accident: **(A)** How and where did in occur? _____
_____ (if more space needed, attach separate sheet)
(B) Nature of Injury _____

5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ Intramural ☐ Interscholastic ☐ Other ☐

6. **(A)** On date of accident what time did school start for this student? _____ AM ☐ PM ☐
(B) What time was student dismissed from school? _____ AM ☐ PM ☐

7. Has a previous claim been filed for this accident? Yes ☐ No ☐

8. **(A)** Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? Yes ☐ No ☐
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary ☐ Jr. High ☐ High ☐ Other ☐

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY? ☐NO ☐YES
IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:
Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: Father _____ Mother _____
Employer's Name: _____ _____
Employer's Address. _____ _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: _____ SIGNATURE: _____
(Claimant, or Parent if Claimant is a minor)

Note: ***Your State Insurance Department requires us to notify you that:*** 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA 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.

Policy/Certificate # _____

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 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 my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company 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. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

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 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.

_____
(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