TRANSAMERICA
TRANSFORM TOMORROW

Transamerica Life Insurance Company
Administrative Office: WebTPA
PO Box 310, Grapevine, TX 76099-0310
Phone: 800-476-4491 (8:00 A.M. - 8:00 P.M. EST M-F)
Fax: 469-417-1960

TransConnect®

Instructions for Submitting a Claim

This Health Claim Package consists of multiple parts. When filing out each section of the package, please keep in mind you should provide complete and accurate information. If you make a claim for your dependent who is over the age of 18, the claimant (patient) needs to sign and date the HIPAA Authorization for the Release of Health-Related ("HIPAA Authorization Form" which is available to you in this package below). You cannot sign this form for the dependent. Take a moment, also, to verify that the doctor completing the Attending Physician's Statement answers all questions and signs and dates the form.

Here are some other common documents and statements needed when filing a certain types of health claims. It's important to note that the list of forms and information within each claim type are generic. **Proof of Treatment can be an itemized bill with an Explanation of Benefits (EOB) from your doctor showing the treatment received and diagnosis; or an itemized summary, including the UB-04 or CMS1500 forms.**

For all claims, the following documents are <u>REQUIRED:</u>

- Claimant's Statement
- Attending Physician's Statement
- HIPAA Authorization

Additional documentation <u>required</u> for specific claims types:

<u>Accident</u>

- Statement(s) showing actual charges/expenses for medical treatment or diagnosis
- Proof of loss - such as hospital statement, ambulance statement, and/or physical therapy

<u>Critical Illness</u>

- Diagnostic reports
- Pathology report diagnosing cancer
- Discharge summary or other medical records indicating the condition and date of diagnosis
- Itemized provider statements with actual charges/expenses incurred for the treatment
- All itemized hospital statements with actual charges/expenses incurred for treatment

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TransConnect® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses

To file a claim: Complete Sections 1 and 2. Attach an itemized statement or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized statement attached (if applicable) to the address above with an Explanation of Benefits (EOB) from your primary medical carrier for these specific expenses.

For which benefit(s) is a claim being filed? Please check all that apply:
Medical__ Accident__ Critical Illness__

SECTION 1 – EMPLOYEE INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Certificate Number/SSN
4a. Mailing Address *(include city, state and zip code)*		5. Phone Number
4b. Street Address *(include city, state and zip code)*		6. Email Address

SECTION 2 – PATIENT'S INFORMATION – Please attach an itemized statement: CMS1500 or UB04.

1. Patient's Full Name	2. Date of Birth	3. Relationship to Employee: ☐Self ☐Spouse ☐Child ☐Stepchild ☐Other

4. Gender ☐ Male ☐ Female	5. Social Security Number	6. Date of Accident (If applicable)	7. If auto accident, was patient: ☐ Driver ☐ Passenger ☐ Unknown

8. Worker's Compensation ☐ Yes ☐ No	9. Date of Service	10. Place of Service (Example: Doctor's Office, Hospital, ER, etc.)	11. Description of Services Performed (Example: x-ray, lab test, etc.)

12. Reason for Visit (Example: Broken Arm, Flu, etc.)	13. Provider's Name and Address
	14. Benefits will be paid directly to you unless you instruct us to pay the provider. ☐ Pay benefits to the provider ☐ Pay benefits to me

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT – To be completed by physician only if no itemized statement. EDI Payer 75261

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.
I hereby request and authorize you to furnish to Transamerica Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

Signature of Patient (If minor, parent/guardian must sign)_____ Date _____

If signed on behalf of another, indicate your relationship (Only if patient is unable to sign) _____

(Expires six months from this date unless indicated or revoked earlier.)

1. Name and Address of Facility where Services Rendered

2. Diagnosis or Nature of Illness or Injury. Relate Diagnosis Code in D to Procedure Code in C

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given: Procedure Code (Identify)	Explain Unusual Services or Circumstances	D Diagnosis Code	E Charges	F

Patient's Account Number	Total Charge	Amount Paid	Balance Due

Physician's Name (please print)	Signature	Date	Tax ID Number or SSN

Mailing Address	City	State	Zip	Phone Number

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**: 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.

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**, **INDIANA** or **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.

Claimant's signature Date

FOR RESIDENTS OF **DISTRICT OF COLUMBIA** or **LOUISIANA**: 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 fines and confinement in prison.

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 **MAINE**, **TENNESSEE** or **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.

Claimant's signature Date

FOR RESIDENTS OF **MARYLAND**, **RHODE ISLAND**, **TEXAS** or **WEST VIRGINIA**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 helps 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 YORK**: Any person who knowingly and with intent to defraud 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 **OHIO**: 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.

Claimant's signature Date

FOR RESIDENTS OF **OREGON**: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the misinformation must be material to the content of the policy, the insurer relied upon the misinformation and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.

Claimant's signature Date

FOR RESIDENTS OF **PENNSYLVANIA**: Any person who knowingly and with intent to defraud 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 a person to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF **PUERTO RICO**: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not more than $10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.

Claimant's signature Date

FOR RESIDENTS OF **VIRGINIA**: Any person who, with the 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 may have violated the state law.

Claimant's signature Date

FOR RESIDENTS OF **ALL OTHER STATES AND TERRITORIES**: 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

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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/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 _____

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

TRANSAMERICA®

Confidential Abuse Information Practices
Abbreviated Notice

Many states prohibit insurers from using confidential abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

In the course of collecting information, confidential abuse information may be collected from persons other than the insured or the claimant.

You have a right of access and correction with respect to all confidential abuse information received and maintained by us.

A protected person is a victim of domestic abuse who has notified an insurer that he or she is or has been a victim of domestic abuse and who is either a present or proposed principal insured or certificate holder, a present or proposed policy-owner, an applicant, or a claimant. A protected person is protected against the collection, use, disclosure or transfer of any confidential abuse information by us which would violate this regulation.

If you wish to be considered a "protected person", please notify us in writing. Please include your name, social security number or policy number, and address.

New Mexico residents may request along version of this Notice of Confidential Abuse Information Practices by sending an email to privacv@transamerica.com. New Mexico residents may also send a written request to "Privacy Official" 6400 C Street SW, Cedar Rapids, IA52499. Please be advised that we have up to three business days to implement your request.