INSTRUCTIONS FOR SUBMITTING A CLAIM

The form has two parts; the Claimant's Statement and the Attending Physician's Statement. When completing the form, 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. When you ask the doctor to complete the **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 bills 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 bills should be submitted for consideration.

If you need help when completing your claim form, have questions about what documents need to be submitted, or need claim forms in the future, our customer service representatives will help you. Please call them Monday through Friday between 7:00 AM and 5:00 PM, Central Standard Time. Their telephone number is **800-251-7254.**

Cancer, Specified Disease, Hospital & Heart. Submit the completed form along with your itemized hospital bills, doctor bills, (surgery, anesthesia, inpatient attending physician bills) chemotherapy, and radiation therapy bills. On claims for cancer and specified disease, submit the first pathology report diagnosing your condition.

Intensive Care. Submit the completed form along with your itemized hospital bill or the UB92 hospital bill.

Accident/Disability. Submit the completed form along with your itemized bills, including emergency medical treatment. They must include a diagnosis. If a police report was prepared, please provide it. *If you are only filing for accident medical expense benefits, it is not necessary to have the Attending Physician's Statement completed.*

Please return the completed claim form and bills to the following address:

Worksite Marketing Division
P. O. Box 8043
Little Rock, AR 72203-8043
FAX: 1-501-371-3196

❑ Transamerica Worksite Marketing
P. O. Box 8063
Little Rock, AR 72203-8063

1-800-251-7254
7 a.m. – 5 p.m. CST

Transamerica Occidental Life Insurance Company
Transamerica Assurance Company
Transamerica Life Insurance Company
Monumental Life Insurance Company
Life Investors Insurance Company of America
Bankers United Life Assurance Company
Members of the AEGON Insurance Group

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.

ADDRESS CHANGE __ Yes __ No

CLAIMANT'S STATEMENT

Insured's Name: ______________________ Date of Birth: ____________ Policy Number(s): __________
Employer: ______________________ Occupation: ______________ Work Phone #: ____________
Patient's Full Name: ______________________ Date of Birth: ____________ Relationship to Insured: __________
Employer: ______________________ Occupation: ______________ Work Phone #: ____________

IF ADDITIONAL SPACE IS NEEDED FOR ANY QUESTION, PLEASE USE AN ADDITIONAL SHEET OF PAPER AND ATTACH TO THIS FORM.

1. Nature of injury or illness: ______________________ When have you had this same or similar condition? ______________
2. When did symptoms first appear or accident occur: ______________________ If an injury, explain fully how and where accident occurred: ____
3. Date first treated/diagnosed: ________________ Name and address of physician (list all physicians consulted): ______________
____
4. What other health insurance do you have? (List all companies) ____
5. Have you been confined to a hospital for this condition? ________ Admission date: ____________ Discharge Date: ____________
Please give name and address of hospital: ____
____
6. Were you confined in an Intensive Care Unit during this hospital stay? __________ If so, for how many days? ______________
7. If you had surgery, please give the name and address of the surgeon: ____
____
8. If you were unable to work due to this condition, please give dates. From ____________ To ______________ If you were restricted to light duty due to this condition, please give dates. From ____________ To ____________ When do you expect to resume your usual duties? ______________________ Are you filing a worker's compensation claim? ______________
9. Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? __________ If so, when ____________________ Please give the name and address of the physician and/or hospital who treated you for this previous condition: ____
____

AUTHORIZATION

BANKERS UNITED LIFE ASSURANCE COMPANY	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	MONUMENTAL LIFE INSURANCE COMPANY	TRANSAMERICA LIFE INSURANCE COMPANY	TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY	TRANSAMERICA ASSURANCE COMPANY

I certify that the above statements are true and correct to the best of my knowledge. I authorize any physician, practitioner or any hospital (including Veteran's Administration or governmental medical facility), clinic or other medical or medically related facility, any medical service organization, any insurance company, worker's compensation carrier, Social Security Office or any other institution or organization to provide the Company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, any medical or other information, requested by it, including information relating to mental illness, use of drugs or use of alcohol concerning this or other illness or injury, so that the same may be included as part of the proof submitted to the Company. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim. I understand that I, or any authorized representative, will receive a copy of this authorization upon request.

DATE ____________ SIGNED ______________________ SIGNED ______________________
(POLICYHOLDER'S SIGNATURE) (SIGNATURE OF PATIENT IF SPOUSE OR DEPENDENT OVER AGE 18)
ADDRESS ____ IS ADDRESS PERMANENT? ☐ YES ☐ NO
(STREET ADDRESS) (CITY) (STATE) (ZIP) TEMPORARY? ☐ YES ☐ NO

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.

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.

ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY THE PATIENT'S ATTENDING PHYSICIAN
(THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.)

1. Policy Holder: ______________________ Policy Number: ______________
2. Name of Patient: ______________________ Age: __________
3. Other Insurance, including Medicaid: ______________________
4. Diagnosis (Please use ICD 9 codes.): ______________ When did symptoms first appear or accident happen? ______________
5. When did the patient first consult you for this condition? ______________ If the patient previously had medical attention, please provide the physician's/hospital's name and address.______________________
   If the claim is for pregnancy, please give due date. ______________
6. Has the patient ever had the same or a similar condition? ☐ Yes ☐ No (If yes, state when and describe.) ______________
7. Describe any other disease or infirmity affecting present condition. ______________________
8. List surgical procedure(s), if any, and include the date of the procedure(s) and the charges. (Please use current CPT codes.) ______________
   ____
9. List the dates of treatment and the charges for each visit. ______________________
10. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement. ______________
    ______________________ Give number of days of ICU confinement. ______________
11. Was Private Duty Nursing required and authorized by you? ☐Yes ☐ No If yes, give dates. ______________
12. Is the patient still under your care for this condition? ☐ Yes ☐ No If discharged, please give date. ______________ If the patient has been referred to another physician, please give that physician's name and address. ______________________
    ____
13. Please give dates the patient was unable to work due to this condition. From __________To __________ If the patient was released to light duty due to this condition, please give dates. From __________To __________ Was patient unable to perform two or more ADL's (Activities of Daily Living) due to this condition? ☐ Yes ☐ No If so, which ones? ______________
14. Has patient ever been treated for a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to this time?
    ☐ Yes ☐ No If yes, please advise when and name and address of doctor/hospital treating patient. ______________
15. Please list conditions and corresponding dates for which you previously treated this patient within the last five years.______________
    ____

DATE: PHYSICIAN'S NAME (PRINTED): SIGNATURE: PHONE NUMBER:

______________________ __(_____)______________

STREET ADDRESS: CITY: STATE: ZIP:

____

TAX IDENTIFICATION NUMBER OR INDIVIDUAL SOCIAL SECURITY NUMBER (REQUIRED BY LAW):

____

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.