INSTRUCTIONS FOR FILLING OUT AN ACCIDENT CLAIM FORM

- Parts 1 and 3 of the claim form must be completed and signed by a parent or guardian (or the student, if an adult). Part 2 of the claim form must be completed and signed by a School official.
  Also, the *HIPAA Authorization To Permit Use and Disclosure of Health Information* must be completed and signed.

- Your School 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 balance 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) **And 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.

- 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
  PO Box 1144
  Glenview, IL 60025

- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please notate this on the bills or in Part 1 of the claim form.

- Only one completed claim form per accident is required to be sent to us. Additional related bills or follow-up treatment to be sent to us should indicate the student's name, school name and/or policy number and date of accident.

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

IMPORTANT:

Please note that your claim will result in a processing delay as the result of not providing us with the following: the completed claim form, 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 800-338-7452.

GTL | GUARANTEE TRUST LIFE

Mail claims to:
PO Box 1144, Glenview, IL 60025
Or fax to: 847-699-1048
Or e-mail to: Claims@gtlic.com
For Customer Service, please call: 800-338-7452

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

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

SPECIAL RISK ACCIDENT CLAIM FORM

PART 1 - 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 Company 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

PART 2 - 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 it 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 _____

PART 3 - 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? ☐ Yes ☐ No

IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:

Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: _____ _____

Employer's Name: _____

Employer's Address: _____

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

DATE: _____ **SIGNATURE** _____

Guarantee Trust Life Insurance Company, PO Box 1144, Glenview, Illinois 60025
800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy / Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. 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. 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 GTL, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent GTL 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.

I understand that GTL 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. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

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.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(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

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.

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

General 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.

Alabama - 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 restitution, fines, or confinement in prison, or any combination thereof.

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.

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.

Arkansas, Louisiana, Rhode Island and West Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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 insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware - 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.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida - Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky - A person who knowingly and with intent to defraud any insurance company or other person 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.

Maine - 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 benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FILES AND CRIMINAL PENALTIES.

Ohio and Oregon - 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.

Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Tennessee, Virginia and Washington State - 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.

Texas - 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.