

Transamerica Life Insurance Company Transamerica Premier Life Insurance Company P.O. Box 8043 Little Rock AR 72203-8043 Claims fax: 866-586-6528 Claims email: TEBclaimsscanning@transamerica.com Claims customer service: 800-251-7254

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.						
CLAIMANT'S STATEMENT						
1. Insured's Full Name	2. Date of Birth			nber	4. Social Security Number	
5a. Mailing Address				6. Phone Number		
5b. Street Address			7. Email Address		Address	
8. Employer 9. Oc		9. Occupa	ccupation 10. V		10. Work Phone Number	
11. Patient's Full Name 12. I		12. Date o	Date of Birth 13. Re		13. Relationship to Insured	
If additional space is needed for	any question, pl	lease use a	an additional sheet of pa	per and a	attach to this form.	
1. Nature of injury or illness				2. When have you had this same or similar condition?		
3. When did symptoms first appear or accident occur? If an injury, explain fully how and where accident occurred. 4. Date first treated/diagnosed					e first treated/diagnosed	
5. Name and address of physician (list all physicians consulted)						
6. Do you have Medicare? Yes Do you have Medicaid? Yes Do you have other health insurance? Yes If yes, what company? No No No					, what company?	
 7. Have you been confined to a hospital for this condition? □Yes □No Admission date: Discharge Date: 			8. Please give name and address of hospital.			
9. Were you confined in an Intensive Care Unit during this hospital stay? □ Yes □ No			10. If you had surgery, please give the name and address of the surgeon			
If yes, for how many days?		10	If		to the constitution of the constitution of the	
11. If you were unable to work due to this condition, please give dates. From To			12. If you were restricted to light duty due to this condition, please give dates. From To			
13. When do you expect to resume your usual duties?		14.	14. Are you filing a Workers' Compensation claim? □ Yes □ No			
15. If applying for waiver of premium, give dates of total From To	disability.	16.	16. 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? ☐ Yes ☐ No If yes, when?			
17. Please give the name and address of the physician and/or hospital who treated you for this the condition in box 16.						

I hereby certify that all information submitted in connection with this claim is true and correct to the best of my knowledge and belief, and I agree that all information and materials subsequently submitted by me or on my behalf for this or any subsequent claim will be true and correct.

Claimant's Signature:

Date: _____



Transamerica Life Insurance Company Transamerica Premier Life Insurance Company P.O. Box 8043 Little Rock AR 72203-8043 Claims fax: 866-224-6547 Claims email: TEBclaimsscanning@transamerica.com Claims customer service: 800-251-7254

ATTENDING PHYSICIAN'S STATEMENT								
1. Insured's Full Name				2. Policy or Certificate Number				
3. Patient's Full Name					4. Patient's Date of Birth			
5. For this patient: Are you being paid □ Yes Are you being paid □ Yes Are you being paid by □ Yes If yes, what company? by Medicare? □ No by Medicaid? □ No other health insurance? □ No					pany?			
6. Diagnosis?	(Please use ICD 10 Codes)	0 Codes) 7. When did symptoms first appear or accident happen?			8. When did the for this condi	e patient first consult y tion?	ou 9. Is this condition work related? □ Yes □ No	
10. If the patient previously received medical treatment, please provide the physician's/hospital's name and address.								
11. If the claim is for pregnancy, please give due date.			12. Has the patient ever had the same or similar condition? □ Yes □ No (If yes, state when and describe)					
13. Describe any other disease or infirmity affecting present condition.			 List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.) 					
15. List the dates of treatment and the charges for each visit.			16. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.					
17. Give number of days of ICU confinement. 18. Was Private Duty Nursing required and authorized by you? □ Yes □ No If yes, give dates. 19. Was Private Duty Nursing required and authorized by you? □ Yes □ No					⊐Yes □No			
and				20. If the patier and addres	patient has been referred to another physician, please give the name Idress.			
If discharged, please give date								
21. Please giv	e dates of total disability for this co	ndition.		22. If the patien	e patient was released to light duty due to this condition, please give date			
From	То			From	То			
23. Was the p If so, whi	atient unable to perform two or mor ch ones?	e ADL's (Activities o	f Daily Livin	ig) due to this cond	lition? □ Yes □] No		
24. 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.								
25. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.								
Date	Physician's Name – Print		Signature	1		Degree	Phone Number ()	
Street address		City			State	Zip	Tax Identification 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.

Claimant's signature Date Commany diagrow in this form. Any person who knowingly presents a fail durit penaltories. Claimant's signature Commany diagrow in this form. Any person who knowingly presents a fail durit penaltories. Claimant's signature Commany diagrow in this form. Any person who knowingly presents a fail durit penaltories. Claimant's signature Commany diagrow in this form. Any person who knowingly presents a fail durit penaltories. Claimant's signature Date FOR RESIDENTS OF CALIFORMA: For your protection california law requires the follow. Claimant's signature Date FOR RESIDENTS OF COLORADO: It is unlavful to knowingly provide faise, incomplete or misleading facts or information to an insurance company or agent of an insurance and will durit appart and adjust an insurer, solution insurance and will durit appart and the subject to criminal and civil penalty in the purpose of defrauding or attempting to defraud the company. Penalties mol induce implexation information is guilty of insurance fault. Claimant's signature Date FOR RESIDENTS OF OBLAWARE. IDAHO, INDIANA or OKLAHOMA: Any person who knowingly and with intent to fail and facta's parture Date Claimant's signature Date FOR RESIDENTS OF DELAWARE. IDAHO, INDIANA o	FOR RESIDENTS OF ALASKA : A person who knowingly and with intent to or deceive an insurance company files a claim containing false, incomplete information may be prosecuted under state law.	sleading or deceive any insurance company, files a statement of claim containing a plete or misleading information is subject to prosecution and punishme	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, incom- plete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.		
the following statement to appear on this form. Any person who knowing FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defail in containing any materially false information, or conceals for the purpose of difficultant insura and containing any false information is subject to fines and containing any false information is subject to fines and containing any false information is subject to fines and containing any false information is subject to criminal and civil penalty not be exceed five thous dollars and the stated value of the claim for the payment of a loss is subject to fines and containing any false information is subject to fines and containing any false information is subject to criminal and civil penalty not be exceed five thous dollars and the stated value of the claim for the payment of a loss is subject to fines and containing any false or misleading information is subject to criminal and civil penalty not be exceed five thous dollars and the stated value of the claim for the apyment of a loss is subject to fines and containing any false or misleading information is subject to criminal and civil penalty not be exceed five thous dollars and the statement of a don containing any false information is subject to criminal and civil penalty in the propose of default penalties may include imprisonment, fines, false information is quilty of a lisuance within the default or regulatory agencies. Claimant's signature Date Claimant's signature Date <t< td=""><td></td><td></td><td></td></t<>					
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Lamant's signature Date FOR RESIDENTS OF CALIFORMA: For your protection California aur equires the follow. Calimant's signature Date Claimant's signature Date 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 or the purpose of defraud ing or attempting to defraud the company. Penalties may include imprisonment, fine, and any person who knowingly and with intent to defraud or knowingly and with intent to facts or information in surger. Claimant's signature Date FOR RESIDENTS OF OBLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company or agent of an insurance or chainant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance with the part to a settlement or award payable from the insurance insure fueld or active and information may be guilty of insurance faud. Claimant's signature Date FOR RESIDENTS OF DELEWARE. IDAHO, INDIANA or OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive any insurance, signature Date FOR RESIDENTS OF PENSYLYANIA: Any person who knowingly and with intent to injure, defraud or deceive any insurance is guilty of a crime and may be subject to fine and agont insurance or conceals for the purpose of defrauding information is guilty of a crime and may be subject to fine and agont insurance or conceals of the purpose of defrauding information is guilty of a crime and any present who knowingly and with intent to injure, defraud or deceive any	ingly presents a false or fraudulent claim for payment of a loss	pject to any insurance company or other person files an application for insurance claim containing any materially false information, or conceals for the pur	e or statement of pose of mislead-		
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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.	or benefit or who knowingly or willfully presents false information in an	ation for that he is facilitating a fraud against an insurer, submits an application	n or files a claim		
Claimant's signature Date Claimant's signature Date	Claimant's signature Date	Claimant's signature Dai	te		
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. FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES : Any person who knowin and with intent to injure, defraud or deceive any insurance company or other per		fraud or FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES : Any person and with intent to injure, defraud or deceive any insurance company	or other person		
Claimant's signature Date files an application for insurance or statement of claim containing any materially finformation or conceals for the purpose of misleading, information concerning any	Claimant's signature Date				
material thereto commits a fraudulent insurance act, which is a crime and subjects s person to criminal and civil penalties.		material thereto commits a fraudulent insurance act, which is a crime a			
Claimant's signature Date		Claimant's signature Dat	te		



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.
- 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