TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Administrative Office: P.O. Box 8043
Little Rock, AR 72203-8043
1-800-251-7254
7 a.m. – 6 p.m. CST
Fax: 866-586-6528

Cancer/Specified Disease Claim Package

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	3. Policy or Certificate Number	4. Social Security Number

5. Address (*include city, state and zip code)*	6. Phone Number
7. Employer	8. Work Phone Number

9. Patient's Full Name	10. Date of Birth	11. Relationship to Insured

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	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

5. Name and address of physician (list all physicians consulted)

6. Do you have Medicare? ❒ Yes ❒ No Do you have Medicaid? ❒ Yes ❒ No Do you have other health insurance? ❒ Yes ❒ No If yes, 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 If yes, for how many days?	10. If you had surgery, please give the name and address of the surgeon
11. If you were unable to work due to this condition, please give dates. From To	12. When do you expect to resume your usual duties?
13. If applying for waiver of premium, give dates of total disability. From To	14. 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?

15. Please give the name and address of the physician and/or hospital who treated you for this previous condition.

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: _____

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. Are you being paid by Medicare? ❒ Yes ❒ No
Are you being paid by Medicaid? ❒ Yes ❒ No
Are you being paid by other health insurance? ❒ Yes ❒ No If yes, what company?

6. Diagnosis? (Please use ICD 9 Codes)	7. When did symptoms first appear or accident happen?	8. When did the patient first consult you for this condition?

9. If the patient previously had medical attention, please provide the physician's/hospital's name and address.

10. Has the patient ever had the same or similar condition? ❒ Yes ❒ No (If yes, state when and describe)	11. Describe any other disease or infirmity affecting present condition.
12. List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.)	13. List the dates of treatment.
14. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.	15. Give number of days of ICU confinement.
16. Was Private Duty Nursing required and authorized by you? ❒ Yes ❒ No (If yes, give dates)	17. Is the patient still under your care for this condition? ❒ Yes ❒ No If discharged, please give date _____
18. If the patient has been referred to another physician, please give the name and address.	19. Please give dates of total disability for this condition. From To

20. 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.

21. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.

Date	Physician's Name – Print	Signature	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.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, 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, LOUISIANA or RHODE ISLAND: 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 HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both

Claimant's signature Date

FOR RESIDENTS OF MAINE, TENNESSEE or VIRGINIA: 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: 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 help 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 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 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 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 five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

TRANSAMERICA®
Employee Benefits

Name of Insurance Company (select one):

☐ **Transamerica Life Insurance Company**

☐ **Transamerica Premier Life Insurance Company**

If no Company is selected, the appropriate box will be checked by the Administrative Office.

Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

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 of Contract Number _____

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