NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the School or School District and the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Policy Number on the claim form. Also, the "HIPPA Authorization To Permit Use and Disclosure of Health Information" must be signed.

- 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 SUBMITTEDWITHIN 90 DAYS OF TREATMENT .

- Please attach itemized bills to the claim form. A balanced 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) The individual charge for each expense

- If you have other (primary) insurance coverage, please send 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
P.O. Box 1148
Glenview, Illinois 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.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

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 Co. 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

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. ____ 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: 5(E)( )14(w)BT/Ft3(w)11(h)rsh(_)5(_/F6 9.96 Tf1 0 0 1 208.49 359.83 Tm[ )15(Y)11(P)BT/F1

YP

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

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

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator located at the facility named below to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. 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. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

Facility Name: _____

Address: _____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company 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. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company 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. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

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.

_____

(Print Please) Name of Patient Date of Birth

_____

Signature of Patient Date

_____