TRANSAMERICA®

Transamerica Life Insurance Company
Administered by: Web-TPA
P.O. Box 310, Grapevine, TX 76099-0310
Claims customer service: 866-975-4641
Claims fax: 469-417-1960

TransChoice® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of it's rights and defenses

To file a claim: Complete Sections 1 and 2. Attach an itemized statement or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized statement attached (if applicable) to the address above.

SECTION 1 – INSURED'S INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Social Security Number	4. Certificate Number
5. Address (*include city, state and zip code*)			
6. Phone Number	7. Group Number (6-10 characters)	8. Marital Status: ☐Married ☐Single ☐Other	9. Gender: ☐Male ☐Female

SECTION 2 – PATIENT'S INFORMATION Please attach itemized statement, CMS 1500 or UB92

1. Patient's Full Name	2. Date of Birth	3. Social Security Number
4. Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Stepchild ☐Other	5. Date of Accident (if applicable)	
6. If auto accident, was patient: ☐Driver ☐Passenger ☐Unknown	7. Is this accident/illness covered by Worker's Compensation? ☐Yes ☐No	

If the health care provider is in your PPO network, payment will be made directly to the provider. Any remaining amount up to your indemnity benefit will be paid to you. If the provider is not in your PPO network, payment will be made directly to you.

Please attach an itemized statement: CMS 1500 or UB92 with itemization or have Section 3 completed by the Attending Physician.

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT To be completed by physician only if no itemized statement

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Transamerica Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

Signature of Patient (If minor, parent/guardian must sign)_____ Date _____

If signed on behalf of another, indicate your relationship (Only if patient is unable to sign) _____

(Expires six months from this date unless indicated or revoked earlier.)

1. Name and Address of Facility where Services Rendered

2. If auto accident, was patient: ☐Driver ☐Passenger ☐Unknown | 3. Is this accident/illness covered by Worker's Compensation? ☐Yes ☐No

4. Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by Reference to Number 1, 2, 3, Etc. or DX Code

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given: Procedure Code (Identify)	C: Explain Unusual Services or Circumstances	D Diagnosis Code	E Charges	F

Your Patient's Account Number	Total Charge	Amount Paid	Balance Due

Physician's Name (please print)	Signature	Date	Tax ID Number or SSN

Street Address	City	State	Zip	Phone 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**: 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.

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** or **LOUISIANA**: 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 **MAINE, TENNESSEE** or **WASHINGTON**: 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, RHODE ISLAND, TEXAS** or **WEST VIRGINIA**: 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 helps 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 insurance 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 **NEW JERSEY**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF **OHIO**: 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.

Claimant's signature Date

FOR RESIDENTS OF **OREGON**: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the misinformation must be material to the content of the policy, the insurer relied upon the misinformation and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.

Claimant's signature Date

FOR RESIDENTS OF **PENNSYLVANIA**: 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 insurance act, which is a crime and subjects such a person to criminal and civil penalties.

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 payment of a loss or any other benefit, or presents more than one 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 $5,000 and not more than $10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.

Claimant's signature Date

FOR RESIDENTS OF **VIRGINIA**: Any person who, with the 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 may have violated the state law.

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

Instructions for Submitting a Death Claim Form

CLAIMANT'S STATEMENT:

1) Every question is to be fully and distinctly answered. If space is insufficient for a full and complete answer, additional information may be attached to the Claimant's Statement. Complete answers will assist the Company in taking prompt action on the claim.

2) The beneficiary or claimant is to complete the Claimant's Statement. If one claimant is making claim under two or more policies he is to complete only one Claimant's Statement covering all policies.

3) If there is more than one beneficiary, each beneficiary must complete the Claimant's Statement.

4) If the policy is payable to the Estate or to the Executors or Administrators of the Insured, the Claimant's Statement should be executed by the Executor or Administrator. A certificate of his appointment must be furnished.

5) If the policy is payable to a minor or a mentally incompetent person, the Claimant's Statement is to be executed by the guardian. A certificate of the guardian's appointment is to be furnished; otherwise contact the Company for instructions.

6) If the policy has been assigned absolutely both in form and in fact, the Claimant's Statement is to be completed by the assignee. If collaterally assigned, the Claimant's Statement is to be completed by both the beneficiary and assignee. (Upon approval of claim, payment will be made payable jointly to beneficiary and assignee, unless otherwise directed.)

7) If all or any portion of the proceeds are assigned for funeral expenses, we require 1) an itemized statement of the total funeral expenses and 2) a valid assignment bearing the signatures of all beneficiaries.

8) Under current federal tax laws, each Claimant is required to provide us with a Social Security or tax reporting number and certify that he/she is not subject to backup withholding. You may be subject to backup withholding if (1) you fail to provide us with your Social Security or tax reporting number, pursuant to Internal Revenue Code ("IRC") Section 3406(a)(1)(A); or (2) you were notified that you have underreported interest or dividend income or you were required to but failed to file a return which would have included reportable interest or dividend payments, pursuant to IRC Section 3406(a)(1)(C). If you are subject to these backup withholding rules, we are required to withhold 28% of any reportable interest payments. **Indicate whether you are subject to backup withholding on question # 6.**

EMPLOYER'S/BUSINESS ENTITY'S STATEMENT:

9) It is necessary that the **"Employer's/Business Entity's Statement"** portion be completed and signed by an authorized representative of the employer/business entity (Policyholder).

10) The employer/business entity must include verification that premium deductions were being made for coverage when the death occurred, as well as proof of the amount of premiums being deducted.

11) A photocopy of the Insured's Enrollment Form is also required.

CERTIFIED COPY OF DEATH CERTIFICATE:

12) In order to process death claims, you must include a certified copy of the death certificate along with this claim form.

NOTE: The cost, if any, of completing claim papers, is to be borne by the beneficiary or claimant.

If the decedent is not the Policy Owner and premiums have been paid by salary deductions, the Policy Owner must contact the employer to discontinue salary deductions for the decedent's policy.

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company

Administered By: Web –TPA
P.O. Box 310, Grapevine, TX 76099-0310

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

AN ADMINISTRATIVE OFFICE FOR:
Transamerica Life Insurance Company

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 3315 LITTLE ROCK AR

POSTAGE WILL BE PAID BY ADDRESSEE

COMPLIANCE DEPARTMENT
TRANSAMERICA WORKSITE MARKETING
P O BOX 8063
LITTLE ROCK AR 72203-9755

NEW BUSINESS COMMENT CARD

Please assist us in our continuing effort to provide the best service and products by completing and returning this comment card
Thank you for your assistance

TRANSAMERICA
LIFE INSURANCE COMPANY

• Transamerica Life Insurance Company

New Business Comment Card

Our Services	Yes	No
1. Did the sales materials you were given explain the coverage clearly?		
2. Did the sales materials accurately describe the coverages you purchased?		
3. Was the application underwritten and policy issued in a timely manner?		
4. Did you replace an existing policy when you purchased this new policy? Yes No		
If yes, policy # and company name		

Comments: _____

_____

Name: _____ Address: _____ City: _____ State ____ Zip _____

Telephone #: _____ Policy Number: _____

Does the above information match your policy? Yes No

WMD-4262 (NEBCO) -0409