HOW TO FILE YOUR CLAIM

We understand you file claims during difficult times, and Transamerica is committed to helping you care for your health without sacrificing your financial future. We know this form asks for a lot of information, but it's all important for processing your claim smoothly. Follow these steps to get started and avoid missing any pieces:

Submitting your claim online is a lot faster, and it lets you track the status anytime, anywhere. Visit www.tebcs.com to complete this form online instead.

When you submit your claim online, ***sign up for direct deposit*** — that's the fastest and safest way to receive any payments you are eligible for.

Sticking with paper? No problem. Just make sure you provide complete and accurate information for each field — missing information can delay your claim. And remember you can always scan your completed form and email it to us at tebclaimsscanning@transamerica.com.

At least three forms are required for everyone who submits a claim. These are all included and clearly labeled in this document:

1. The ***Claimant's Statement*** is the core document of your claim. It describes your claim and captures critical information about you and your policy/certificate.

2. The ***HIPAA Authorization Form*** lets us access your personal health information to determine how your policy/certificate covers your claim. Note that if you file a claim for a dependent over age 18, the claimant (patient) needs to sign and date this form themselves — you cannot sign it for them.

3. The ***Physician's Statement*** is a document you give to the doctor who provided the treatment related to your claim. Take a moment to verify the doctor answered all the questions, including signing and dating the form.

Your claim may require additional documentation. Go to the next page to see what you need — we've tried to make it as easy as possible.

Questions?

VISIT: tebcs.com

EMAIL: tebcustresp@transamerica.com

CALL: 888-763-7474 (weekdays 7am – 6pm CST)

Transamerica Financial Life Insurance Company / Transamerica Life Insurance Company
Transamerica Claims PO Box 219 Cedar Rapids IA 52406-0219

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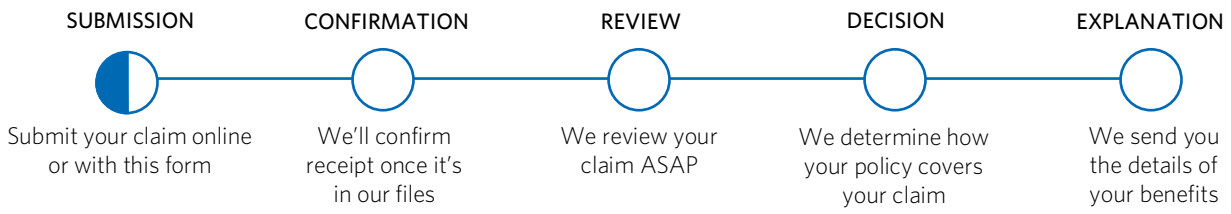
INFORMATION YOU NEED TO FILE A CLAIM

FORMS INCLUDED IN THIS DOCUMENT	*ACCIDENT*	*DISABILITY*	*CRITICAL ILLNESS*	*CANCER*	*HEART OR STROKE*	*ICU / HOSPITAL INDEMNITY*
Claimant's statement	●	●	●	●	●	●
HIPAA Authorization	●	●	●	●	●	●
Physician's Statement	●	●	●	●	●	●
Medical History Form		●		●		
Employer's Statement		●				

MATERIALS TO SUMBIT WITH YOUR CLAIM						
Itemized statements of medical charges	●			●	●	●
Police report (motor vehicle accidents)	●	●				
Discharge summary	●	●	●			
First report of injury		●				
Diagnostic report			●			
Pathology report			●	●		
Date of diagnosis			●			
Medicare, Medicaid, insurance statements				●	●	
Ambulance statement				●	●	●

WHAT HAPPENS AFTER YOU FILE A CLAIM?



Go to the next page and let's get started!

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1 CLAIMANT'S STATEMENT

You must complete this Claimant's Statement for any claim you file. This information helps us determine how your policy/certificate covers your claim.

CLAIM TYPE

What is the policy/certificate you're filing this claim under? It can be more than one, so check all that apply:

☐ Accident ☐ Disability ☐ Critical Illness ☐ Cancer ☐ Heart/stroke ☐ Intensive Care / Hospital Indemnity

Provide the name and address of your employer. If you are retired, indicate that below.

CONTACT INFORMATION

1. Primary insured's full name	2. Date of birth	3. Policy/certificate number	4. Social Security number
5a. Mailing address			
5b. Street address			5c. Apartment or Unit
6. Phone number	7. Email address		
8. Patient's full name	9. Date of birth	10. Relationship to insured	

ABOUT YOUR INJURY OR ILLNESS

For questions 11-16, complete the information that applies to your situation. If you need more space for any question, you can use an additional sheet of paper and attach it to this form.

11. Nature of injury or illness

12. When did your symptoms first appear, or when did the accident occur? If this is related to an injury, explain fully how, when, and where accident occurred.

13a. Date first treated or diagnosed	14. Were you hospital confined? Please include the hospital's name, address, and phone.	15. Have you been previously diagnosed with cancer?
13b. Is this injury related to a work incident? If yes, please describe. ☐ Yes ☐ No	☐ Yes: from to	☐ *Yes* ☐ *No*

16a. Do you have ***Medicare?***	16b. Do you have ***Medicaid?***	16c. Do you have other health insurance?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes — Company name: _____ ☐ No

1 CLAIMANT'S STATEMENT

INCOME SOURCES

Answer question 17 only if you're filing a disability claim. In that case, you also will need to have your employer complete the Employer's Statement, which is included with this document.

17. To the best of your knowledge, indicate if you have filed for, or are receiving income from, any of the following sources:

Salary continuance or sick leave ☐ Yes ☐ No If yes, how many hours since you last worked? _____

Extended illness benefit or time off ☐ Yes ☐ No If yes, how many hours since you last worked? _____

	APPLIED	RECEIVING	AMOUNT	FREQUENCY	DATES
Short-term disability	☐	☐	$_____	_____	_____ to _____
Worker's compensation	☐	☐	$_____	_____	_____ to _____
Social Security	☐	☐	$_____	_____	_____ to _____
Dependent Social Security	☐	☐	$_____	_____	_____ to _____
No Fault (income replacement)	☐	☐	$_____	_____	_____ to _____
Retirement / Pension	☐	☐	$_____	_____	_____ to _____
Permanent Total Disability	☐	☐	$_____	_____	_____ to _____
Other (identify below)	☐	☐	$_____	_____	_____ to _____

_____

Don't forget to sign and date this Claimant's Statement below: we can't evaluate your claim without your signature!

All the above answers and statements are true and complete and correctly recorded. I read and understand the appropriate Fraud Warning. I understand that the furnishings of forms by the company does not constitute an admission that there is any insurance coverage in force or payable.

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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

Claimant's signature Date (MM/DD/YYYY)

_____

Printed name

2 HIPAA AUTHORIZATION

This authorization complies with the HIPAA Privacy Rule, and it's required for all claims. A copy of this authorization will be considered as valid as the original.

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, long term care facilities (including assisted living facilities), home health care entities and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the ***entire medical record*** and any other protected health information concerning the insured/patient to the Transamerica Financial Life Insurance Company and/or Transamerica Life Insurance Company (the "Companies"), their affiliates and reinsurers, and any business associate, agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency (including MIB, Inc. formerly known as the Medical Information Bureau) or independent claim administrator acting on behalf of any of the Companies (the "Permitted Recipients"). This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, diagnosis, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), prescription drug information, substance abuse records, medical records, medical notes, and medical recordings. This authorization also consents to disclosure of information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, AIDS and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization (e.g., they are temporarily revoked only as to this authorization) and I instruct the Providers to release and disclose the ***entire medical record of the insured/patient and any other of their protected health information as noted above*** without restriction.

The information disclosed is for the purpose of claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations by the Permitted Recipients.

This authorization shall remain in force for 24 months, or in the case of long-term care or disability claims for the duration of the claims under such policy, whichever is longer, following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Customer Service Department, 6400 C Street SW, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers with a copy sent to the Companies. I understand that a revocation is not effective to the extent that any of the Providers has relied on this authorization or to the extent that the Companies have relied on a signed authorization or have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing

2 HIPAA AUTHORIZATION

privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies. I understand that I have a right to receive the Notice of Health Information Privacy Practices and a copy of this signed authorization upon request.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the entire medical record of the insured/patient, the Companies may not be able to proceed with claims or eligibility processing or make any benefit payments. I acknowledge that (1) if I am signing on behalf of the insured/patient, I am legally permitted to do so as the personal representative of the insured/patient, and (2) I have received a copy of this authorization.

Don't forget to sign and date below: we can't evaluate your claim without this!

Name of insured/patient (please print)

Date of birth (MM/DD/YYYY)

Signature of insured/patient or their personal representative

Date signed (MM/DD/YYYY)

Description of personal representative's authority or Relationship to insured/patient

Policy or contract number

3 ATTENDING PHYSICIAN'S STATEMENT

This physician's statement is required for all claims. Give this page to your doctor to complete, then submit it together with the other parts of your claim.

1. Primary 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 by...

Medicare?	Medicaid?	Another insurance company?
☐ Yes	☐ Yes	☐ Yes — Company name: _____
☐ No	☐ No	☐ No

6. Diagnosis (use ICD 10 Codes)	7. When did accident/symptoms first occur?	8. When did patient first consult you for this condition?

9. For pregnancy claims, give due date and delivery type.	10. For cancer claims: to your knowledge, has the patient ever had cancer prior to this diagnosis? ☐ No ☐ Yes (date) _____

11. List all dates of treatment (including surgical procedures, hospitalizations, ICU) and include the date and charges of each treatment/procedure. Use current CPT codes.

12. Is the patient still under your care for this condition? If no, give name and address of new treating physician: ☐ Yes ☐ No	13. Did you advise the patient to cease work? ☐ Yes, from _____ to _____ ☐ No	14a. Dates of total disability for this condition (from/to): 14b. Next treatment date:

15. If the patient was released to light duty due to this condition, give date range:	16. Was the patient unable to perform two or more activities of daily living due to this condition? If so, which ones? ☐ Yes ☐ No

CONTACT INFORMATION

Street address	City	State	ZIP

Phone number	Tax Identification Number	Degree

_____ _____

Physician's signature Date (MM/DD/YYYY)

_____

Printed name

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MEDICAL HISTORY FORM

You need to submit a medical history form for any disability claim, and other policies may require it too — so if you're not sure if your claim requires it, go ahead and fill it out. Submit it together with the other parts of your claim.

INSURED PERSON'S DETAILS

Name of insured person	Social Security number
Policy/certificate number(s)	

DETAILS ABOUT MEDICAL PROVIDERS

Please provide information about all the medical providers (including doctors and hospitals) the insured person consulted for treatment related to this claim. We'll then request information about their treatment of the insured to help us understand how the policy covers the claim. You can attach extra pages if you need more space.

Family physician name		Phone number	
Street address	City	State	ZIP
Reason for visit		Dates consulted or year treated	

OTHER PROVIDER — if applicable

Provider name		Phone number	
Street address	City	State	ZIP
Reason for visit		Dates consulted or year treated	

OTHER PROVIDER — if applicable

Provider name		Phone number	
Street address	City	State	ZIP
Reason for visit		Dates consulted or year treated	

MEDICAL HISTORY FORM

OTHER PROVIDER — if applicable

Provider name		Phone number	
Street address	City	State	ZIP
Reason for visit		Dates consulted or year treated	

DETAILS ABOUT MEDICATIONS

Please provide details about the medications the insured used for any treatment related to this claim (this information is usually on the prescription bottle or container). Attach extra pages if you need more space.

Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		

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 also 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 (MM/DD/YYYY)

Claimant's printed name

EMPLOYER'S STATEMENT

You need to submit this page only if your claim is a **disability claim.** Give this page to your employer to complete, and then submit it together with the other parts of your claim.

1. Company Name			2. Phone number
3. Street address	4. City	5. State	6. ZIP
7. Full name of employee / insured person			8. Social Security number
9. Date this employee / insured person was last actively at work			
10. Employee / insured person's job title/major job duties (Attach a copy of job description)			
11a. Did disability occur on the job? ☐ Yes ☐ No	11b. Job classification ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very heavy		
12. If the employee were medically cleared to return to work with restrictions, or on light duty, can you accommodate? ☐ Yes ☐ No — If no, attach letter explaining why accommodation is not possible			
13. Date employee/insured person returned to work: _____ ☐ Full time ☐ Part time ☐ Light duty	14. If "Part time" due to partial disability, provide earnings: $_____ from/to dates _____		
15. Employee/insured person's status of employment after first day absent: ☐ Active ☐ Leave of absence ☐ Laid off ☐ Retired ☐ Terminated ☐ Other: _____			
16. Employee/insured person's current status of employment: ☐ Active ☐ Leave of absence ☐ Laid off ☐ Retired ☐ Terminated Effective: _____			17. Annual salary
18. To the best of your knowledge, indicate if employee/insured person has filed for/is receiving income from any of these:			
Salary continuance/Sick leave ☐ Yes ☐ No	If yes, indicate number of hours as of last date worked: 90		
EIB or PTO ☐ Yes ☐ No	If yes, indicate number of hours as of last date worked: 99		
Worker's compensation ☐ Yes ☐ No	If yes, indicate number of hours as of last date worked: 1		

The above statements are true and complete to the best of my knowledge and belief.

Signature of Employer's authorized representative

Date (MM/DD/YYYY)

Printed name

Title

Phone number

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Transamerica Claims PO Box 219 Cedar Rapids IA 52406-0219

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CLAIM FRAUD WARNINGS

Your state may require the following notice: 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.

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, District of Columbia, Louisiana, New Mexico, Rhode Island, Texas, 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 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 any 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 agents 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, Idaho, Indiana. 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.

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.

Kentucky, 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 person to criminal and civil penalties.

Maine, Tennessee, Virginia, 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.

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.

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 N. H. Rev. Stat. Ann. § 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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio. Any person that knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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.