NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT THIS CLAIM FORM

NOTE TO MEMBERS

Our objective at Guarantee Trust Life Insurance Company is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service.

WHEN TO FILE A CLAIM

1. Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

HOW TO FILE A CLAIM

Members Responsibility:

1. All questions must be answered in full by the Member in order for us to process the claim.
   - **It is very important that the name of Group or Association be indicated on claim form.**

2. Employers portion of claim form must be completed and signed.

3. Attending Physician's Statement on claim form must be completed and signed.

4. The "Authorization To Permit Use and Disclosure of Health Information" must be signed and returned **with** the claim form.

IMPORTANT: Incomplete forms will result in a processing delay of your claim.

Also, please note that in furnishing this or other claim forms for the convenience of the member, GUARANTEE TRUST LIFE INSURANCE COMPANY does not admit any liability or waive any rights. GUARANTEE TRUST LIFE INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary by GUARANTEE TRUST LIFE INSURANCE COMPANY. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

WHERE TO FILE A CLAIM

Send all completed forms to:

Guarantee Trust Life Insurance Company
PO Box 1148
Glenview, IL 60025

If you have any questions, please contact our Customer Service Department at (800)622-1993.

G·T·L

Guarantee Trust Life Insurance Company • P.O. Box 1148 • Glenview, IL 60025
Group Claim Department Phone Number: 800-622-1993 • FAX: 847-803-1835
Email: Special_riskdiv@gtlic.com

ACCIDENTAL DISMEMBERMENT & LOSS OF SIGHT CLAIM FORM

TO BE COMPLETED BY INSURED MEMBER

Group or Association Name: United Family Association (UFA) ACC174-175 series

Name of Insured Member: _____ Alternate Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone Number: (_____) _____ - _____ Insured Member Date of Birth: _____/_____/_____

Social Security Number/Member Identification Number: _____

Patient's Name and Relationship (If other than Insured Member): _____

Patient's Date of Birth: _____/_____/_____ Male ❑ Female ❑

1. Date of Accident: _____/_____/_____ 1a. Hour: _____:_____ AM ❑ PM ❑
2. Description of Accident:
   A) How did it occur? _____
   _____
   B) Where did it occur? City: _____ State: _____ Location: _____
   C) Nature of Injury? _____
   D) Due to this injury, were or are you currently totally disabled? Yes ❑ No ❑
3. Did this accident occur while playing in an Intercollegiate Club or Organized Sport? Yes ❑ No ❑
   If yes, please indicate the type of sport: _____
4. Was this a work related accident/injury? Yes ❑ No ❑ 4a. Are you self employed? Yes ❑ No ❑
4b. Was this filed with Workers' Compensation? Yes ❑ No ❑
4c. If no, please explain why: _____

5. Is the Patient covered by any other plan (including Workers' Compensation) for expenses related to this accident? Yes ❑ No ❑
5a. If yes, provide the following information of the Insurance Carrier:
   Insured/Member/Owner Name: _____
   Carrier Name: _____
   Address: _____
   (Street) (City) (State) (Zip Code)
   Phone Number: (_____) _____- _____ Policy Number: _____
   Effective Date: _____/_____/_____ Termination Date (if applicable): _____/_____/_____

PLEASE NOTE: Incomplete claim forms will result in process delay.

I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy.

_____ _____/_____/_____
Signature of Insured Member Date

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Member Signature: _____ **Print Name:** _____ **Date:** ____/____/_____

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth: ____/____/____

SSN: _____-_____-_____

1. Diagnosis (describe nature of illness or injury): _____

_____

2. Is condition the result of: Illness ❑ Accident ❑
2a. What date did accident occur?: ____/____/____

3. If injury, how do you understand accident occurred?: _____

_____

4. Has the patient had treatment for the same or related condition before?: Yes ❑ No ❑
4a. If yes, when and by whom? : _____

_____

5. On what date were you first consulted for this condition? : ____/____/____
5a. Give dates of treatment: ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

6. If hospitalized, give name and address of hospital and dates of confinement:

_____

Name Address Dates - From/To

_____

Name Address Dates - From/To

7. Was this Patient referred from another Physician? Yes ❑ No ❑
If yes, give name and address: _____
Name Address City State Zip

8. If surgery performed, please describe: _____

_____

9. Total Disability (unable to do any work) From: ____/____/____ To: ____/____/____
Partial Disability From: ____/____/____ To: ____/____/____

10. Prognosis: _____

11. If still disabled, when do you expect patient will be able to resume any work? : ____/____/____

I hereby authorize GUARANTEE TRUST LIFE INSURANCE COMPANY or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to: _____

Signed: _____ Degree: _____ Date: ____/____/____

Address: _____

Social Security or Tax ID No.: _____ Phone Number: (____) _____ - _____

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Alabama	**Kansas**	**North Carolina**	**South Dakota**
Arkansas	**Louisiana**	**North Dakota**	**Texas**
California	**Massachusetts**	**Nebraska**	**Utah**
Connecticut	**Michigan**	**Nevada**	**Vermont**
Georgia	**Missouri**	**Puerto Rico**	**Wisconsin**
Iowa	**Mississippi**	**Rhode Island**	**West Virginia**
Illinois	**Montana**	**South Carolina**	**Wyoming**

Generic Fraud Warning **(to be used for above states only)**
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alaska, Delaware, Idaho, Indiana, 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.

Colorado, Washington D.C., Hawaii, Maine, Tennessee, 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 may include imprisonment, fines or a denial of insurance coverage.

Arizona, Minnesota, New Jersey, New Mexico - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 RSA 638:20.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Rhode Island - 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.

Washington State - 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-338-7452

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 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.

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 is valid from the date signed for the duration of the claim.

_____

(Print Please) Name of Patient — Date of Birth

_____

Signature of Patient — Date

_____

(Please Print) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient

_____

Signature of Authorized Representative or Next of Kin — Date