Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
P.O. Box 869097 Plano ,TX 75086-9097
Claims fax: 866-224-6547
Claims email: TEBclaimsscanning@transamerica.com
Claims Customer Service: 800-251-7254

Disability Benefit Claim Form

Claimant's Statement

1. Full Name:	2. Date of Birth:	3. Certificate Number:	4. Home Phone:

5a. Mailing Address	6a. City	7a. State	8a. Zip Code
5b. Street Address:	6b. City:	7b. State:	8b. Zip Code:

9. Email Address

10. Date Accident or Illness began:

11. Is this disability due to:
☐ Motor Vehicle Accident ☐ Other Accident or Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy
If disability is due to a Motor Vehicle Accident, please submit a copy of the police report.
If disability is work related, please submit a copy of the First Report of Injury

12. Please describe your medical condition(s) or injury causing disability. If related to an accident or injury, describe when, where and how the accident or injury occurred. _____

13. Have you been confined to a hospital for this condition? ☐ Yes ☐ No If "Yes", please submit all pages of the Discharge paperwork.

14. Have you ever had or been treated for the same or similar condition? ☐ Yes ☐ No If "Yes", please describe when, where, and by whom.

_____

_____

_____

15. Name and address of hospital(s) and Doctor(s):

Name	Address	City	State	Zip

16. Last date worked:	17. Date returned to work: ☐ Full Time ☐ Part Time	18. If not returned, date anticipated to return:

19. Are you currently employed by another employer? ☐ Yes ☐ No If "Yes", please have an additional employer's statement completed by each employer.

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

Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked _____

EIB/PTO ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked_____

	Applied for	Receiving	Amount	Frequency	From/To Dates
Short Term Disability	☐	☐	$_____	_____	_____/_____
Worker's Compensation	☐	☐	$_____	_____	_____/_____
State Disability	☐	☐	$_____	_____	_____/_____
Social Security	☐	☐	$_____	_____	_____/_____
Dependent Social Security	☐	☐	$_____	_____	_____/_____
No Fault (Income Replacement)	☐	☐	$_____	_____	_____/_____
Retirement/Pension	☐	☐	$_____	_____	_____/_____
Permanent Total Disability	☐	☐	$_____	_____	_____/_____
Other (Please identify) _____	☐	☐	$_____	_____	_____/_____

The information above is true and correct to the best of my knowledge.

Claimant's Signature: _____ Date: _____

Employer's/Business Entity's Statement

1. Company Name:			2. Phone Number:
3. Street Address:	4. City:	5. State:	6. Zip Code:
7. Name of Employee/Insured Person:	8. Social Security #:		
9. Date Employee/Insured Person last worked:			Date of Hire:
10. Employee's/Insured Person's job title/major job duties **(Please attach a copy of job description):**			
11. Job Classification: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy	12. Annual Salary:		13. Average hours worked per week:
14. Does this employee/insured person contribute to Social Security? ☐ Yes ☐ No If "No", was the employee hired after 4/1/86? ☐ Yes ☐ No	15. Is the disability premium paid by the employee/insured person? ☐ Yes ☐ No If "Yes", ☐ Before or ☐ After taxes		
16. Percentage of the employee/insured person's disability premium you pay:	17. Did disability occur on the job? ☐ Yes ☐ No		
18. Employee's/Insured Person's status as of first day absent: ☐ Active ☐ Vacation ☐ Leave of Absence ☐ Laid Off ☐ Terminated ☐ Retired If other than Active, Please explain:_____			
19. If employee was medically cleared to return to work with restrictions or on light duty can you accommodate? ☐ Yes ☐ No If no, please attach a letter stating why accommodation is not possible.			
20. Date employee/insured person returned to work: _____ ☐ Full Time ☐ Light Duty ☐ Part Time ☐ Not returned	21. If "Part Time", due to partial disability, provide earnings: Amount: _____ From/To Dates: _____		
22. To the best of your knowledge, indicate if the employee/insured person has filed for or is receiving income from any of the following sources: Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked _____ EIB/PTO ☐ Yes ☐ No If "Yes", indicate number of hours as of last date worked_____ Worker's Compensation ☐ Yes ☐ No			
23. Will employee/insured person earn any future Salary Continuance/Sick Leave/EIB/PTO? ☐ Yes ☐ No If "Yes", please indicate date: _____			
24. Employee/Insured Person's current status of employment: Date of Hire: _____ ☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Effective: _____			

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

Employer's/Business Entity's Authorized Representative

Name (please print) _____ Title _____ Phone # _____

Signature _____ Date _____

Return to: Transamerica P.O. Box 869097 Plano ,TX 75086-9097
Fax 866-224-6547
Or to TEBclaimsscanning@transamerica.com

Attending Physician's Statement		
Patient Name:	Date of Birth:	Social Security No.:

Instructions: The following sections must be completed and signed by the attending physician.
Please complete all applicable sections of this form. In all situations, you must complete the signature block at the bottom of this form.

Normal Pregnancy – If unable to work before or after delivery, please attach a letter of medical necessity

a) Expected Delivery Date: _____
Date first unable to work: _____

b) Actual Delivery Date: _____
Date Hospitalized: _____

c) Delivery Type:
☐ Vaginal ☐ C-Section

All Other Conditions

1. Primary ICD-10: _____-_____ Diagnosis: _____
Secondary ICD-10: _____-_____ Diagnosis: _____
Other ICD-10: _____-_____ Diagnosis: _____

2. Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No ☐ Unknown

3. Date symptoms first appeared or accident happened:

4. Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", when and describe: _____

5. Is patient still under your care for this condition? ☐ Yes ☐ No
Final date of treatment: _____

6. Initial date of treatment: _____ Most recent date of treatment: _____

7. Frequency of follow-up: ☐ Weekly ☐ Monthly ☐ Other: _____

8. Dates of services since disability commenced:
_____
_____
_____

9. Was patient hospitalized? ☐ Yes ☐ No
Name of Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Admitted: _____ Discharged: _____

10. Was surgery performed? ☐ Yes ☐ No If "Yes", CPT 4 code(s): _____ Date surgery performed: _____

11. Was the patient referred to you? ☐ Yes ☐ No If "Yes", give the referring physician's name and address.
Physician's Name: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

12. Has patient reached a point of maximum medical improvement? ☐ Yes ☐ No

13. Did you advise patient to cease work? ☐ Yes ☐ No If "Yes", From: _____ To: _____

14. When is the patient expected or estimated to return to work?
Date of return: _____
☐ To regular occupation: ☐ Full Time ☐ Part time ☐ Light duty
☐ To any other occupation: ☐ Full Time ☐ Part time ☐ Light duty

Please describe the patient's prognosis and work/activity restrictions. _____
_____

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

Physician's Name (please print) _____ Degree: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ Tax ID Number: _____

Signature: _____ Date: _____

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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.

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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 or Contract Number _____

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

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Medical Provider List

Please Complete and Return This List

Name of Insured :	Social Security Number :	Policy Number :

Please list below the names, addresses, and phone numbers of all medical providers, including doctors and hospitals, consulted or used by you 1 year from the issue date of the policy.

Dates: beginning__________ through__________

Provider Name		Phone Number	Reason for Visit
Street Address			
			Dates consulted or Year treated
City	State	Zip Code	

Provider Name		Phone Number	Reason for Visit
Street Address			
			Dates consulted or Year treated
City	State	Zip Code	

Provider Name		Phone Number	Reason for Visit
Street Address			
			Dates consulted or Year treated
City	State	Zip Code	

Provider Name		Phone Number	Reason for Visit
Street Address			
			Dates consulted or Year treated
City	State	Zip Code	

The following Prescriptions have been filled (see label on Rx bottle).

Name/Address of Pharmacy	Doctor	Drug Name	Condition Testing

****If additional space is needed, please use the other side of this form****

Signature ______________________ Date ______________