

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.



Name of Insurance Company (select one):

☐ Transamerica Life Insurance Company

☐ Transamerica Premier Life Insurance Company

If no Company is selected, the appropriate box will be checked by the Administrative Office.

Administrative Office: P.O. Box 8063

Little Rock, Arkansas 72203-8063

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