National Teachers Associates Life Insurance Company

HEALTH, ACCIDENT, & DISABILITY CLAIM FORM

Customer Service Center **1-888-671-6771**
ntalife.com

Instructions for filing a claim for benefits:

1. Complete each section on **page 1** and the Policyowner and Patient Information on **page 2**.
2. Sign and date **page 1**.
3. Have your physician complete and sign the *Attending Physician Statement* on **page 2**.
4. Sign and date the *Authorization for Release of Health Related Information* on **page 4**.
5. Submit itemized bills for each benefit claimed (e.g. itemized medical bill, hospital discharge summary, etc.).
6. For disability claims: Have your employer complete and sign the *Employer Statement* on **page 2**.
7. For cancer claims: Submit a pathology report documenting a positive cancer diagnosis.

Unanswered or incomplete items can cause a delay in processing.

List Your Policy Number(s) Here:

POLICY #	POLICY #	POLICY #	POLICY #

POLICYOWNER INFORMATION

NAME OF POLICYOWNER	SOCIAL SECURITY NUMBER - -	OCCUPATION	
ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS ☐ I would like to learn more about how I can receive claim updates and other correspondence via the email address I have provided.

PHONE
Home: ( ) - Mobile: ( ) - Work: ( ) -

PATIENT INFORMATION

NAME OF PATIENT	SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /

RELATIONSHIP TO POLICYOWNER	HEIGHT ft. in.	WEIGHT lbs.	SEX ☐ Male ☐ Female	PHONE ( ) -

INFORMATION CONCERNING ACCIDENT, DISABILITY, OR SICKNESS

Filing a Claim for an Accident Policy

Date of accident: _____/_____/_____ Time of accident: _____ ☐ a.m. ☐ p.m. Where did the accident occur? _____

How did the accident/injury occur? _____

Describe injuries:

Filing a Claim for a Disability Policy

Dates of Disability: From _____/_____/_____to _____/_____/_____ Date last worked: _____/_____/_____ Date released to return to work: _____/_____/_____

This disabililty is related to: ☐ Sickness ☐ Injury Please describe. _____

Is the patient receiving retirement benefits under any federal or state-sponsored retirement program? ☐ YES ☐ NO

If "Yes", please describe:

Is the disability/condition a result of employment-related activities? ☐ YES ☐ NO If yes, is the patient seeking Worker's Compensation benefits? ☐ YES ☐ NO

Filing a Claim for a Specified Disease Policy (e.g. Cancer or Heart Attack, Heart Disease & Stroke)

Date of sickness: _____/_____/_____ at _____ ☐ a.m. ☐ p.m. Date symptoms first appeared: _____/_____/_____

Nature of sickness: _____

Has patient ever had the same or similar condition? ☐ YES ☐ NO If "Yes" give details:

Date: _____/_____/_____ Reason: _____ Doctor: _____ Hospitalized? ☐ YES ☐ NO

Has patient been treated for anything else within the past two years? ☐ YES ☐ NO If "Yes" give details:

Date: _____/_____/_____ Reason: _____ Doctor: _____ Hospitalized? ☐ YES ☐ NO

Date: _____/_____/_____ Reason: _____ Doctor: _____ Hospitalized? ☐ YES ☐ NO

By signing below, I represent that all information on this form is true and correct and that I have read the state-specific fraud warning on page 3.

(Signed) Patient _____ Date _____/_____/_____
A parent or legal guardian must sign if the patient is under the age of 18.

(Signed) Policyowner _____ Date _____/_____/_____

SEND THIS COMPLETED FORM TO THE CLAIMS PROCESSING CENTER BY:
EMAIL: Claims@NTALife.com **FAX:** 1-855-51 CLAIM (25246) **MAIL:** P.O. Box 2369 Addison, TX 75001-2369

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POLICYOWNER & PATIENT INFORMATION: To be completed by the Policyowner

POLICY OWNER'S NAME	DATE OF BIRTH	POLICY #	PATIENT NAME
	/ /		

ATTENDING PHYSICAN STATEMENT: To be completed by the Attending Physician

DATE OF FIRST SYMPTOM (IF SICKNESS) OR DATE OF INJURY	DATE FIRST CONSULTED FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ○ Yes ○ No IF "YES" PLEASE GIVE THE DATE:
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

NAME AND ADDRESS OF REFERRING PHYSICIAN (IF APPLICABLE)

NAME AND ADDRESS OF HOSPITAL WHERE SERVICES RENDERED (IF APPLICABLE)	DATE ADMITTED	DATE DISCHARGED
	_____/_____ / _____	_____/_____/_____

Diagnosis or Nature of Sickness or Injury	ICD-9 or ICD-10 Code
1.	
2.	
3.	

Is this condition related to pregnancy? ○ Yes ○ No LMP _____/_____/_____ Date of Delivery _____/_____/_____ Method of delivery: ○ Vaginal ○ C-Section

Date of Service	Place of Service	CPT Code	Describe Medical Procedures and Services Provided	Charges
/ /				
/ /				
/ /				

For Disability Claims, please fill out the following:

DATES OF TOTAL DISABILITY (UNABLE TO WORK)	DATES OF PARTIAL DISABILITY	DATE PATIENT RELEASED TO RETURN TO WORK	DATE OF NEXT SCHEDULED OFFICE VISIT FOR THIS CONDITION
_____/_____/_____ to_____/_____/_____	_____/_____/_____ to _____/_____/_____	_____/_____/_____	_____/_____/_____

FUNCTIONAL LIMITATIONS (i.e. physical hinderances such as the inability to walk or stand for extended periods of time)

CURRENT TREATMENT PLAN

ADDITIONAL COMMENTS

PROVIDER NAME	PROVIDER ADDRESS	PHONE ( ) - FAX ( ) -
PHYSICIAN PRINTED NAME	SPECIALTY	PHYSICIAN'S FEDERAL ID #
PHYSICIAN'S SIGNATURE Date / /		PATIENT ACCOUNT #

EMPLOYER STATEMENT: To be completed by the Patient's Employer

DATE STOPPED WORK DUE TO DISABILITY	NAME OF EMPLOYER	PHONE ( ) - FAX ( ) -
_____ / _____ / _____		
DATE RETURNED TO WORK _____ / _____ / _____	EMPLOYER ADDRESS	

IS THE EMPLOYEE OFF WORK DUE TO DISABILITY THAT AROSE FROM EMPLOYMENT-RELATED ACTIVITIES?	IS THE EMPLOYEE SEEKING BENEFITS UNDER WORKER'S COMPENSATION OR A SIMILAR EMPLOYER SPONSORED PLAN?
○ YES ○ NO	○ YES ○ NO

SIGNATURE/TITLE OF OFFICIAL REPRESENTATIVE

Date / /

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EMAIL: Claims@NTALife.com **FAX:** 1-855-51 CLAIM (25246) **MAIL:** P.O. Box 2369 Addison, TX 75001-2369

STATE SPECIFIC FRAUD WARNINGS

Please review the following fraud warning for your state before signing the Claimant Statement on page 1.

Alaska-Warning: 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-Warning: 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.

California-Warning: 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.

Colorado-Warning: 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 insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, and Oklahoma-Warning: 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-Warning: 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-Warning: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, and Washington-Warning: 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 benefits.

Minnesota-Warning: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey-Warning: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico-Warning: 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 civil fines and criminal penalties.

New York-Warning: Any person who knowingly 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 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-Warning: 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.

Pennsylvania-Warning: 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.

Texas-Warning: 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.

All Other States-Warning: 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.

National Teachers Associates Life Insurance Company
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

Authorization for Release of Health-Related Information

This Authorization Complies with HIPAA Privacy Rule

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, Pharmacy Benefit Managers and other medically related facilities) to disclose all medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) and all pharmacy records to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company
Attn: Director of Compliance
4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

_____ _____
Signature of Individual Whose Information is to be Disclosed Date

_____ _____
Printed Name of Individual Policy Number

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