PROTECTING THE HEART OF OUR COMMUNITY

NTA LIFE CLAIM PACKET

ONLINE CLAIM SUBMISSION IS NOW AVAILABLE

Submit claims online through your MyNTALife account!

Included in this packet you will find:

1. Instructions for Completing the *Health, Accident, and Disability Claim Form*
2. *Health, Accident, and Disability Claim Form*
3. *Authorization for the Release of Health-Related Information Form*

Direct Deposit: Receive claim payments faster

- **Fast and Convenient**
  Claims payments are deposited directly into your account. No more waiting by the mailbox or driving to the bank.
- **Sign Up Today**
  Simply complete the *Direct Deposit/ACH Agreement* form in the "Forms" section of ntalife.com and submit with your claim forms. We will do the rest. It's that easy!
- **Already Signed Up?**
  You don't have to do a thing. We will use your most recent election or you can make changes to your preferences through your MyNTALife account.

MyNTALife: Access and convenience in one place

Start experiencing the benefits of a **MyNTALife** account today:

- **Fast** and **convenient** access
- **Pay** premiums
- File and manage **Claims**
- Update your **Profile** and **Communication** delivery **Preferences**
- Manage **Direct Deposit** elections

and more…

Visit us at **ntalife.com** and register for your account today!

THANK YOU FOR CHOOSING NTA LIFE!

Questions? We're here to help.
888.671.6771

How to Complete and Submit a Health, Accident, & Disability Claim Form

GENERAL TIPS FOR COMPLETING AND SUBMITTING A CLAIM FORM

-Fully complete each page of the claim form. Unanswered or incomplete items can cause a delay in processing.
-Read all instructions before filling out the claim form.
-Submit the completed form as directed at the bottom of the form.

PAGE ONE: CLAIMANT STATEMENT

1. List the policy number for each policy on which you are filing a claim.
2. Fully complete the **Policyowner Information** section.
3. Fully complete the **Patient Information** section.
   -The Patient is the covered individual who received medical treatment and/or services.
4. Fully complete each applicable section under **Information Concerning Accident, Disability or Sickness** (i.e. To claim benefits on a disability policy, complete the "Filing a Claim for a Disability Policy" section).
5. Sign and date the bottom of the form.
   -Before signing, review page 3 for the fraud warning for your state.
   -A parent or legal guardian must sign if the patient is under 18 years of age.

PAGE TWO: ATTENDING PHYSICIAN'S STATEMENT & EMPLOYER'S STATEMENT

6. Complete the **Policyowner** and **Patient Information** sections.
7. Submit a copy of the **Attending Physician Statement** section to your physician for completion.
8. For disability claims only: Submit a copy of the **Employer Statement** section to your employer for completion.

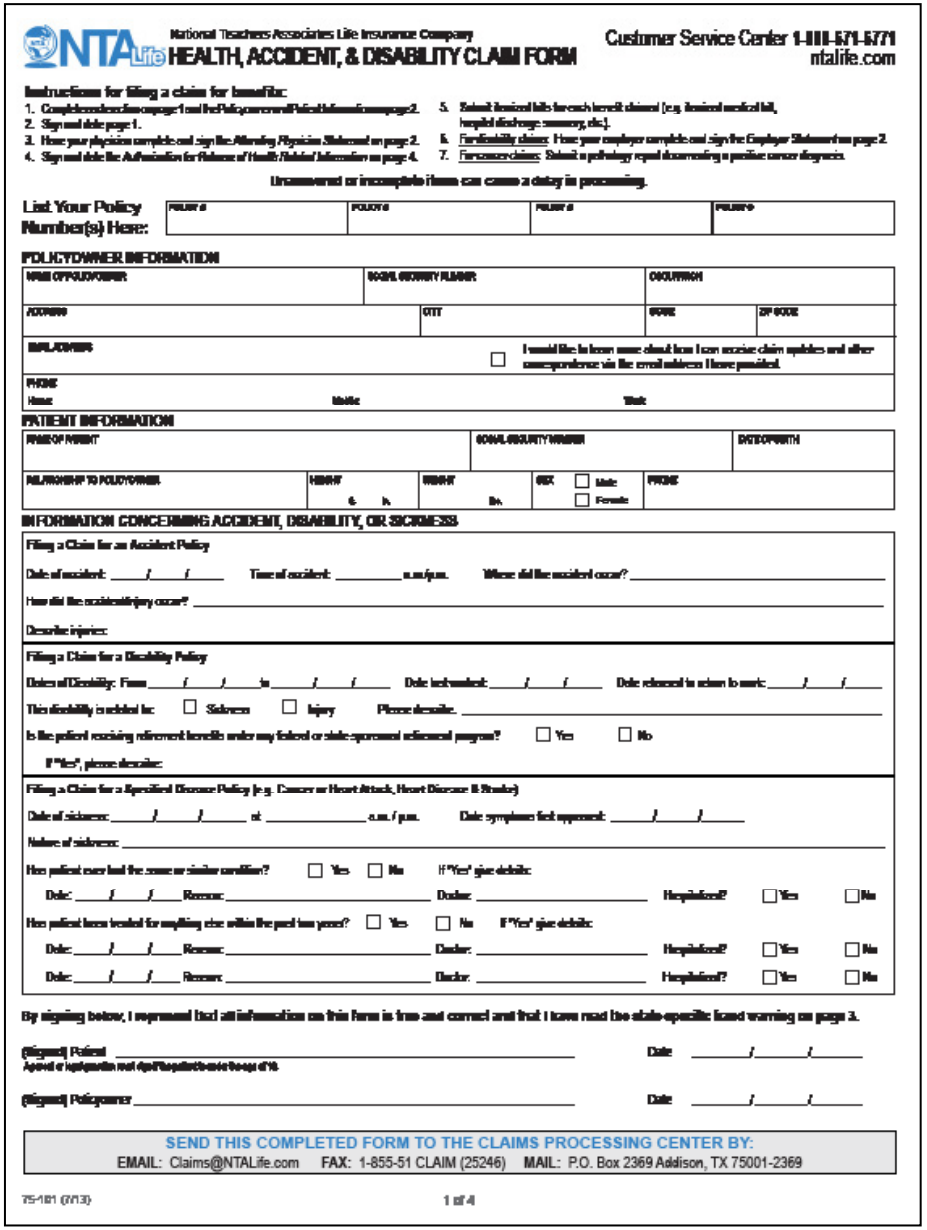
PAGE THREE: STATE-SPECIFIC FRAUD WARNING

9. This page contains the state-specific fraud warning reviewed in step 5.

PAGE FOUR: AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

10. Review and sign the *Authorization For Release of Health-Related Information* form.

The arrows, which correspond with the numbered instructions, indicate where to fill in the requested information on the claim form.



PAGE ONE: CLAIMANT STATEMENT

National Teachers Associates Life Insurance Company

HEALTH, ACCIDENT, & DISABILITY CLAIM FORM

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

6 → **POLICYOWNER & PATIENT INFORMATION: To be completed by the Policyowner**

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

7 → **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) _____/_____/_____ to _____/_____/_____	DATES OF PARTIAL DISABILITY _____/_____/_____ to _____/_____/_____	DATE PATIENT RELEASED TO RETURN TO WORK _____/_____/_____	DATE OF NEXT SCHEDULED OFFICE VISIT FOR THIS CONDITION _____/_____/_____

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 and Physician Information (physician signature is required for all claim types)

PROVIDER NAME	PROVIDER ADDRESS	PHONE ( ) - FAX ( ) -

PHYSICIAN PRINTED NAME	SPECIALTY	PHYSICIAN'S FEDERAL ID #

PHYSICIAN'S SIGNATURE X Date / /	PATIENT ACCOUNT #

8 → **EMPLOYER STATEMENT: To be completed by the Patient's Employer for disability claims only**

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? ☐ YES ☐ NO	IS THE EMPLOYEE SEEKING BENEFITS UNDER WORKER'S COMPENSATION OR A SIMILAR EMPLOYER SPONSORED PLAN? ☐ YES ☐ NO

SIGNATURE/TITLE OF OFFICIAL REPRESENTATIVE
X Date / /

SEND THIS COMPLETED FORM TO THE CLAIMS PROCESSING CENTER BY:
EMAIL: Claims@NTALife.com **FAX:** 1-855-512-5246 **MAIL:** P.O. Box 2369 Addison, TX 75001-2369

75-101 (8/13) 2 of 4 Attending Physician and Employer Statement

PAGE TWO: ATTENDING PHYSICIAN AND EMPLOYER STATEMENT

9 →

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.

3 of 4

PAGE THREE: STATE-SPECIFIC FRAUD WARNINGS

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, other medically related facilities, other insurance companies, and MIB, Inc.) 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 ("NTA Life") and affiliated entities (including its reinsurers) 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.

NTA Life 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 also, authorize NTA Life, or its reinsurers, to make a brief report of my protected health information to MIB.

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.

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

_____ _____
Printed Name of Individual Policy Number

75-307 (1/15)

PAGE FOUR: AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

Please fully complete the claim form to avoid any delays in processing your request for policy benefits.

If you have any questions regarding the completion of this form please contact our Customer Service Center, toll-free, at **1.888.671.6771**. One of our Associates will be glad to assist you.

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	WEIGHT	SEX	PHONE
	ft. in.	lbs.	○ Male ○ Female	( ) -

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

National Teachers Associates Life Insurance Company

HEALTH, ACCIDENT, & DISABILITY CLAIM FORM

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

POLICYOWNER & PATIENT INFORMATION: To be completed by the Policyowner

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

ATTENDING PHYSICIAN 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) _____/_____/_____ to _____/_____/_____	DATES OF PARTIAL DISABILITY _____/_____/_____ to _____/_____/_____	DATE PATIENT RELEASED TO RETURN TO WORK _____/_____/_____	DATE OF NEXT SCHEDULED OFFICE VISIT FOR THIS CONDITION _____/_____/_____

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? ○ YES ○ NO	IS THE EMPLOYEE SEEKING BENEFITS UNDER WORKER'S COMPENSATION OR A SIMILAR EMPLOYER SPONSORED PLAN? ○ YES ○ NO

SIGNATURE/TITLE OF OFFICIAL REPRESENTATIVE

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

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.

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, other medically related facilities, other insurance companies, and MIB, Inc.) 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 ("NTA Life") and affiliated entities (including its reinsurers) 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.

NTA Life 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 also, authorize NTA Life, or its reinsurers, to make a brief report of my protected health information to MIB.

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