



PROTECTING THE HEART OF OUR COMMUNITY

NTA LIFE CLAIM PACKET

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*

Receive Claim Payments Faster with Direct Deposit

- **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?**
Existing direct deposit customers don't have to do a thing. We will use your most recent election.
- **Need To Make Changes?**
Simply change your preferences through your MyNTALife account or complete a new form.

MyNTALife: Access and Convenience in One Place

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

- Gain **fast** and **convenient** access to claim and policy information
- View your claim status **24 hours** a day
- **Pay** premiums online
- Manage your profile and communication delivery preferences
- **Update** 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.*



National Teachers Associates Life Insurance Company
HEALTH, ACCIDENT, & DISABILITY CLAIM FORM

Customer Service Center 1-800-571-5771
ntalife.com

Instructions for filing a claim for benefits:

1. Complete this claim on page 1 and file 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
EMPLOYER <input type="checkbox"/> I would like to be kept aware of 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		BIRTHDATE	
RELATIONSHIP TO POLICYOWNER		SEX <input type="checkbox"/> Male <input type="checkbox"/> 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 returned to work to work: / /

This disability 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: _____

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

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 ten 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.


(Signature) Patient _____ Date: / /
Agent or legal guardian not Applicable to this page of 4

(Signature) 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

75-101 (07/3) 1 of 4

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 PHYSICIAN STATEMENT: To be completed by the Attending Physician**
 DATE OF FIRST SYMPTOM (IF SICKNESS) _____ DATE FIRST CONSULTED FOR THIS CONDITION _____ HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? Yes No
 OR
 DATE OF INJURY ____/____/____ 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
 1. _____ ICD-9 or ICD-10 Code _____
 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 hindrances 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 () - _____
 PHYSICIAN PRINTED NAME _____ SPECIALTY _____ FAX () - _____
 PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ PHYSICIAN'S FEDERAL ID # _____
 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 () - _____
 DATE RETURNED TO WORK ____/____/____ EMPLOYER ADDRESS _____ FAX () - _____
 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: 1-855-512-5246 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

STATE SPECIFIC FRAUD WARNINGS

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

9 → **Alabama-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 amount 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 therein, 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.

Signature of Individual Whose Information is to be Disclosed

Date

Printed Name of Individual

Policy Number

75-307 (1/15)

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.

10 →

PAGE FOUR: AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION



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:

Table with 4 columns for POLICY #

POLICYOWNER INFORMATION

Form with fields for NAME OF POLICYOWNER, SOCIAL SECURITY NUMBER, OCCUPATION, ADDRESS, CITY, STATE, ZIP CODE, EMAIL ADDRESS, PHONE (Home, Mobile, Work)

PATIENT INFORMATION

Form with fields for 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: ___

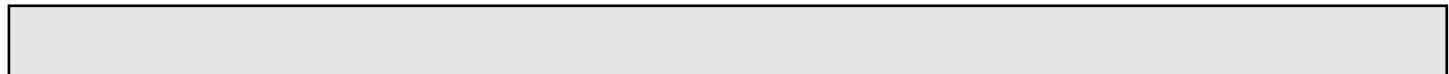
Filing a Claim for a Disability Policy
Dates of Disability: From ___/___/___ to ___/___/___ Date last worked: ___/___/___ Date released to return to work: ___/___/___
This disability is related to: Sickness Injury Please describe. ___
Is the patient receiving retirement benefits under any federal or 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 ___/___/___





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? IF "YES" PLEASE GIVE THE DATE:	Yes No
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	

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