NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT A DISABILITY CLAIM FORM

NOTE TO MEMBERS

Our objective at Guarantee Trust Life Insurance Company is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service.

WHEN TO FILE A CLAIM

1. Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

HOW TO FILE A CLAIM

Members Responsibility:

1. All questions must be answered in full by the Member in order for us to process the claim.
   - **It is very important that the name of Group or Association be indicated on claim form.**

2. Employers portion of claim form must be completed and signed.

3. Attending Physician's Statement on claim form must be completed and signed.

4. The "Authorization To Permit Use and Disclosure of Health Information" must be signed and returned **with** the claim form.

IMPORTANT: Incomplete forms will result in a processing delay of your claim.

Also, please note that in furnishing this or other claim forms for the convenience of the member, GUARANTEE TRUST LIFE INSURANCE COMPANY does not admit any liability or waive any rights. GUARANTEE TRUST LIFE INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary by GUARANTEE TRUST LIFE INSURANCE COMPANY. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

WHERE TO FILE A CLAIM

Send all completed forms to:

Guarantee Trust Life Insurance Company
PO Box 1148
Glenview, IL 60025

If you have any questions, please contact our Customer Service Department at (800)622-1993.

G·T·L

Guarantee Trust Life Insurance Company
P.O. Box 1148 • Glenview, IL 60025
Claims Department Phone Number: 800-622-1993 • FAX: 847-803-1835

ACCIDENT DISABILITY CLAIM FORM

STATEMENT OF MEMBER

Group or Association Name: Evolution Benefits Association ACC164-165 series Member #: _____

Member Name: _____ Patient Name: _____ Alternate Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone #: (____) _____ - _____ Date of Birth: ____/____/____ SS #: _____ - ____ - _____ Male ❑ Female ❑

Occupation: _____ Normal weekly hours: _____

Describe duties: _____

_____

1. Date accident occurred: ____/____/____ 1a. Explain fully how and where accident occurred: _____

_____

2. Did this accident occur while playing in an Intercollegiate Club or Organized Sport? Yes ❑ No ❑
3. Date of first medical attention: ____/____/____ 4. Physician's name and address: _____

_____

4. Total Disability (unable to do any work) From: ____/____/____ To: ____/____/____
   Partial Disability From: ____/____/____ To: ____/____/____
5. Give names of all physicians and hospitals who treated you for this injury causing the disability:
   Name: _____ Name: _____
   Address: _____ Address: _____
6. If you have not resumed work, what is your expected return date? : ____/____/____
7. Do you have Disability Insurance with any other organization or entity? Yes ❑ No ❑

7a. If yes, give name and amount of disability benefits of each: _____

8. Are you claiming under any Workers' Compensation or other Employer's Liability Law? Yes ❑ No ❑

8a. If yes, give name and address of insurance company or other entity to which claim is made: _____

_____

8b. If no, why not? _____

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Member Signature: _____ **Date:** ____/____/____

BE SURE TO SIGN ABOVE & SECURE COMPLETED STATEMENT OF EMPLOYER & ATTENDING PHYSICIAN

STATEMENT OF EMPLOYER

Employee's Name: _____ Social Security Number: _____ - _____ - _____

1. Date Employed: ____/____/____

1a. Was Employee in your active employment when disability began? Yes ❑ No ❑

1b. If no, please explain: _____

2. Occupation: _____ 2a. Normal weekly hours: _____
3. Did accident happen on the job? Yes ❑ No ❑
4. Date last worked: ____/____/____ Date resumed work: ____/____/____
5. Is Employee totally disabled (unable to do any work)? Yes ❑ No ❑
6. If still disabled, when is Employee expected to return to work? : _____
7. Is claim being made under any Workers' Compensation or other Employer's Liability Law? Yes ❑ No ❑

7a. If yes, give name and address of company to which claim is made: _____

_____

Employer's Signature: _____ **Date:** _____/_____/_____

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth: ____/____/____

SSN: _____-_____-_____

1. Diagnosis (describe nature of illness or injury): _____

_____

2. Is condition the result of: Illness ❑ Accident ❑
2a. What date did accident occur?: ____/____/____

3. If injury, how do you understand accident occurred?: _____

_____

4. Has the patient had treatment for the same or related condition before?: Yes ❑ No ❑
4a. If yes, when and by whom? :_____

_____

5. On what date were you first consulted for this condition? : ____/____/____
5a. Give dates of treatment: ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

6. If hospitalized, give name and address of hospital and dates of confinement:

_____
Name Address Dates - From/To

_____
Name Address Dates - From/To

7. Was this Patient referred from another Physician? Yes ❑ No ❑
If yes, give name and address: _____
Name Address City State Zip

8. If surgery performed, please describe: _____

_____

9. Total Disability (unable to do any work) From: ____/____/____ To: ____/____/____
Partial Disability From: ____/____/____ To: ____/____/____

10. Prognosis: _____

11. If still disabled, when do you expect patient will be able to resume any work? : ____/____/____

I hereby authorize GUARANTEE TRUST LIFE INSURANCE COMPANY or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to: _____

Signed:_____ Degree: _____ Date: ____/____/____

Address: _____

Social Security or Tax ID No.: _____ Phone Number: (____) _____ - _____

Dear Insured: *Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Connecticut	**Massachusetts**	**Nebraska**	**South Dakota**
Georgia	**Michigan**	**North Carolina**	**Utah**
Hawaii	**Missouri**	**North Dakota**	**Vermont**
Iowa	**Mississippi**	**Nevada**	**Wisconsin**
Illinois	**Montana**	**South Carolina**	**Wyoming**
Kansas			

General Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama – 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 restitution, fines, or confinement in prison, or any combination thereof.

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.

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.

Arkansas, Louisiana, Rhode Island and West Virginia – 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.

California – For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 – 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 – 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.

District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A 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 – 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.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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 in RSA 638:20.

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

New Mexico – 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.

Ohio and Oregon – 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.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Tennessee, Virginia and Washington State – 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.

Texas – 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.

Guarantee Trust Life Insurance Company
P.O Box 1145, Glenview, Illinois 60025
(800) 338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

_____
(Print Please) Name of Patient — Date of Birth

_____
Signature of Patient — Date

_____
(Please Print) Name of Authorized Representative, or Next of Kin

_____
Relationship of Authorized Representative or Next of Kin to Patient

_____
Signature of Authorized Representative or Next of Kin — Date