TRANSAMERICA
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Transamerica Life Insurance Company
Monumental Life Insurance Company

CANCER OR SPECIFIED DISEASE POLICY
Instructions and Check-List for Submitting a Claim

To help us process your claim as quickly as possible, you must provide us with all the necessary information. Below is a check-list of the items we need to begin reviewing your claim. While these items are typically all that is needed, we may request additional information to process your claim.

For an Initial Claim Submission:

- ☐ Pathology Report from your Doctor, if your claim is for cancer
- ☐ Attending Physician's Statement for your Doctor to complete (page 2 of 4 in enclosed Claim Package)

The following documents that you need to complete:

- ☐ Claimant's Statement (page 1 of 4)
- ☐ Required Fraud Warning Statements (page 3 of 4)
- ☐ Authorization for the Release of Health Information (page 4 of 4)

Please be sure that you provide all information requested on these documents completely and accurately and sign and date each document.

For an Initial Claim Submission and All Subsequent Claim Submissions:

- **The following information from your Doctor/Medical Provider/Hospital**:
  - ☐ Itemized Statements reflecting the procedures or treatments from the Doctor or medical provider (preferable on the Form CMS-1500) or the hospital. The itemized statement should include the following:
    - For chemotherapy and prescription drugs:
      - Description of drugs used
      - Procedure codes
      - Number of units of each drug
    - For radiation therapy:
      - Description of procedures performed
      - Procedure codes
      - Number of units of each treatment

- **If your procedure or treatment was also covered by Medicare, Medicaid or any other insurance, please provide**:
  - ☐ Information showing actual charges of your treatment such as a copy of all Summary Notices from Medicare or Medicaid or Explanation of Benefits from your other insurance.
  - ☐ Statements from your Doctor/Medical Provider/Hospital showing payments or adjustments from Medicare, Medicaid or your other insurance.

If you need help when completing your claimant's statement or have questions about what documents need to be submitted, our Claims Customer Service representatives will help you. Please call Monday through Friday between 7:00 AM and 6:00 PM, Central Standard Time at 800-251-7254.

Please return completed documents to the following address:

Transamerica Worksite Marketing
P.O. Box 8043
Little Rock, AR 72203-8043

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Name of Insurance Company (select one):

☐ Transamerica Life Insurance Company
☐ Monumental 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's/Insured's Name/Signature:	_____	Date	_____
Personal Representative's (if any) Name/Signature:	_____	Patient's/ Insured's SSN	_____
Patient's/Insured's Address:	_____	Patient's/ Insured's Date of Birth	_____
Personal Representative's (if any) Address	_____	Personal Representative's Phone Number	_____
Description of Personal Representative's Authority or Relationship to Patient/Insured	_____		
Policy or Contract Number	_____		

Claimants should retain a copy of this signed document for their records