

# **NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM**

## **INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM**

- The claim form must be completed and signed by the School or School District **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Policy Number on the claim form. Also, the "HIPPA Authorization To Permit Use and Disclosure of Health Information" must be signed.
- **PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED WITHIN 90 DAYS OF THE ACCIDENT. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED WITHIN 90 DAYS OF TREATMENT.**
- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
  - 1) **The date(s) of treatment,**
  - 2) **The type(s) of service,**
  - 3) **The diagnosis,**
  - 4) **The medical provider's name and address**
  - 5) **The individual charge for each expense.**
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.
- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

**GUARANTEE TRUST LIFE INSURANCE COMPANY  
P.O. Box 1148  
Glenview, Illinois 60025**

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, School or School District Name, Policy Number, and date of accident.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

### **IMPORTANT:**

**Please take note that your claim will result in processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.**

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

NAME OF SCHOOL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY NO. \_\_\_\_\_

IMPORTANT! THIS  
INFORMATION MUST BE GIVEN  
OR CLAIM WILL BE RETURNED

GUARANTEE TRUST LIFE INS. CO.  
P.O. Box 1148  
Glenview, IL 60025  
(800) 622-1993

**ASSIGNMENT OF BENEFITS:**

Dr.: \_\_\_\_\_ Hosp.: \_\_\_\_\_ Other: \_\_\_\_\_  
Addr: \_\_\_\_\_ Addr: \_\_\_\_\_ Addr: \_\_\_\_\_  
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_  
Claimant – if an ADULT

**SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)**

1. Claimant's FULL NAME \_\_\_\_\_ Alternate Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_
2. Claimant's Address: Street or RFD \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Date of Accident \_\_\_\_\_ 20\_\_\_\_ Hour \_\_\_\_\_ AM  PM
4. Description of Accident: (A) How and where did it occur? \_\_\_\_\_  
\_\_\_\_\_ (if more space needed, attach separate sheet)  
(B) Nature of Injury \_\_\_\_\_
5. Description of Activity (What was the Claimant doing at time of injury?) \_\_\_\_\_  
If Athletics, name sport \_\_\_\_\_ Intramural  Interscholastic  Other
6. (A) On date of accident what time did school start for this student? \_\_\_\_\_ AM  PM   
(B) What time was student dismissed from school? \_\_\_\_\_ AM  PM
7. Has a previous claim been filed for this accident? Yes  No
8. (A) Name of School Authority supervising Activity \_\_\_\_\_  
(B) Was Supervisor a witness? Yes  No   
(C) If not, when was accident reported to School Authority? \_\_\_\_\_

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary  Jr. High  High  Other

**I certify that the above information is correct to the best of my knowledge and belief.**

Date of this report \_\_\_\_\_ Signature of Official \_\_\_\_\_ Title \_\_\_\_\_

**PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.**

9. Do you have other insurance, which covers this condition, either group, individual, automobile medical or liability? Yes  No   
If Yes, give Company Name and Phone Number \_\_\_\_\_ Policy # \_\_\_\_\_
10. Parents Name: Father \_\_\_\_\_ Mother \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

**I certify that the above information is correct to the best of my knowledge and belief.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ ADDR \_\_\_\_\_  
(Parent/Guardian or claimant if an Adult)

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.

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
**1275 Milwaukee Avenue, Glenview, Illinois 60025**  
**1-800-622-1993**

**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 located at the facility named below 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.

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

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