



Transamerica Life Insurance Company  
 Monumental Life Insurance Company  
 Administrative Office: P.O. Box 8043  
 Little Rock, AR 72203-8043  
 1-800-251-7254  
 7 a.m. – 6 p.m. CST  
 Fax: 866-586-6528

# Health Multipurpose Claim Package

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

### CLAIMANT'S STATEMENT

1. Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Social Security Number
5. Address (include city, state and zip code)			6. Phone Number
7. Employer	8. Occupation		9. Work Phone Number
10. Patient's Full Name	11. Date of Birth	12. Relationship to Insured	

If additional space is needed for any question, please use an additional sheet of paper and attach to this form.

1. Nature of injury or illness	2. When have you had this same or similar condition?
3. When did symptoms first appear or accident occur? If an injury, explain fully how and where accident occurred.	4. Date first treated/diagnosed
5. Name and address of physician (list all physicians consulted)	
6. Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what company?	
7. Have you been confined to a hospital for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No  Admission date: _____ Discharge Date: _____	8. Please give name and address of hospital.
9. Were you confined in an Intensive Care Unit during this hospital stay? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, for how many days?	10. If you had surgery, please give the name and address of the surgeon
11. If you were unable to work due to this condition, please give dates.  From _____ To _____	12. If you were restricted to light duty due to this condition, please give dates.  From _____ To _____
13. When do you expect to resume your usual duties?	14. Are you filing a workers' compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. If applying for waiver of premium, give dates of total disability.  From _____ To _____	16. Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, when?
17. Please give the name and address of the physician and/or hospital who treated you for this previous condition.	

I hereby certify that all information submitted in connection with this claim is true and correct to the best of my knowledge and belief, and I agree that all information and materials subsequently submitted by me or on my behalf for this or any subsequent claim will be true and correct.

Claimant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ATTENDING PHYSICIAN'S STATEMENT

1. Insured's Full Name		2. Policy or Certificate Number		
3. Patient's Full Name		4. Patient's Date of Birth		
5. Are you being paid <input type="checkbox"/> Yes <input type="checkbox"/> No by Medicare?      Are you being paid <input type="checkbox"/> Yes <input type="checkbox"/> No by Medicaid?      Are you being paid by <input type="checkbox"/> Yes <input type="checkbox"/> No other health insurance? If yes, what company?				
6. Diagnosis? (Please use ICD 9 Codes)	7. When did symptoms first appear or accident happen?	8. When did the patient first consult you for this condition?	9. Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. If the patient previously had medical attention, please provide the physician's/hospital's name and address.				
11. If the claim is for pregnancy, please give due date.		12. Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state when and describe)		
13. Describe any other disease or infirmity affecting present condition.		14. List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.)		
15. List the dates of treatment and the charges for each visit.		16. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.		
17. Give number of days of ICU confinement.		18. Was Private Duty Nursing required and authorized by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates.		
19. Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If discharged, please give date _____		20. If the patient has been referred to another physician, please give the name and address.		
21. Please give dates of total disability for this condition. From _____ To _____		22. If the patient was released to light duty due to this condition, please give dates. From _____ To _____		
23. Was the patient unable to perform two or more ADL's (Activities of Daily Living) due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which ones?				
24. Has patient ever been treated for a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to this time? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please advise when and name and address of doctor/hospital treating patient.				
25. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.				
Date	Physician's Name – Print	Signature	Degree	Phone Number (    )
Street address		City	State	Zip
				Tax Identification Number





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:

- 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.
- 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.
- 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.**
- 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**