NGL Insurance Group
100 Years of Service

Guarantee Trust Life is the claims administrator for National Guardian Life
Mail claims to: Guarantee Trust Life Insurance Company
P.O. Box 1148 - Glenview, IL 60025
Contact us at: 888-556-5525

CLAIM FORM

Name of College/University Illinois Central College

Policy Number: 12N-125-343-S

Name of Claimant: ____________________

Male ❒ **Female** ❒ **Date of Birth:** _____/______/______

Address: ____________________
(Street) (City) (State) (Zip)

Nature of your Condition: ____________________

____

When did this condition start? ____________________

Have you ever been treated for this condition before? Yes ❒ No ❒

If Yes, when? ____________________

Was this an accident? Yes ❒ No ❒

If yes, please give details (When, When and How it occurred): ____________________

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____

DO YOU HAVE ANY OTHER INSURANCE, which covers this condition, including Group, Individual Health and/or Accident or Motor Vehicle? Yes ❒ No ❒

Name of the insurance company, phone number and policy number: ____________________

____

Were you insured under a health plan immediately preceding the effective date of coverage under this plan?
Yes ❒ No ❒
If yes, please provide the name of the insurance company, phone number and policy number:

____

Effective Date of policy: ________/_______/________
Termination Date: _____/______/_________

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.

Arkansas	**Kansas**	**North Carolina**	**South Dakota**
California	**Louisiana**	**North Dakota**	**Texas**
Connecticut	**Massachusetts**	**Nebraska**	**Utah**
Georgia	**Michigan**	**Nevada**	**Vermont**
Iowa	**Missouri**	**Puerto Rico**	**Wisconsin**
Illinois	**Mississippi**	**Rhode Island**	**West Virginia**
	Montana	**South Carolina**	**Wyoming**

Generic 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, Delaware, Idaho, Indiana and Oklahoma - 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.

Colorado, Washington D.C., Hawaii, Maine, Tennessee and Virginia - 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 coverage.

Arizona, Minnesota, New Jersey and New Mexico - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio and Oregon - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

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.

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.

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.

Rhode Island - 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.

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.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
Administered by
Guarantee Trust Life Insurance Company
P.O. Box 1148 - Glenview, IL 60025

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by Guarantee Trust Life Insurance Company 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 to our Administrator, 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 Guarantee Trust Life Insurance Company (GTL) 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 (GTL) 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 our Administrator, Guarantee Trust Life Insurance Company (GTL), pursuant to this Authorization, the information will remain protected by Guarantee Trust Life Insurance Company (GTL) in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

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(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