



**Guarantee Trust Life Insurance Company**  
**P.O. Box 1148**  
**Glenview, Illinois 60025      800-622-1993**

**CLAIM FORM**

**Name of Organization:** \_\_\_\_\_

**Name of Claimant:** \_\_\_\_\_ **Alternate Name:** \_\_\_\_\_

**Male**  **Female**  **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**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):** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

---

**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 company and phone number:** \_\_\_\_\_  
**If yes, please give the other policy number:** \_\_\_\_\_

**Were you insured under a health plan immediately preceding the effective date of coverage under this plan?**  
 Yes  No

**If yes, give name and phone number of the company:** \_\_\_\_\_

**Your policy number:** \_\_\_\_\_

**Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Termination Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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 have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have 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 is valid from the date signed for the duration of the claim.

---

(Print Please) Name of Patient

---

Signature of Patient and Date

---

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

---

Relationship of Authorized Representative or Next of Kin to Patient (attach appropriate documentation)

---

Signature of Authorized Representative or Next of Kin \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_

Policy Number \_\_\_\_\_