



**Transamerica Financial Life Insurance Company**  
 P.O. Box 8043 Little Rock, AR 72203-8043  
 Claims fax: 866-224-6547  
 Claims email: TEBclaimsscanning@transamerica.com  
 Claims Customer Service: 800-251-7254

**Disability  
Benefit  
Claim Form**

**Claimant's Statement**

1. Full Name:		2. Date of Birth:		3. Certificate Number:		4. Home Phone:	
5a. Mailing Address				6a. City		7a. State	8a. Zip Code
5b. Street Address:				6b. City:		7b. State:	8b. Zip Code:
9. Email Address							
10. Date Accident or Illness began:		11. Is this disability due to: <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other Accident or Sickness <input type="checkbox"/> Work-related Injury/Sickness <input type="checkbox"/> Pregnancy If disability is due to a Motor Vehicle Accident, please submit a copy of the police report. If disability is work related, please submit a copy of the First Report of Injury					
12. Please describe your medical condition(s) or injury causing disability. If related to an accident or injury, describe when, where and how the accident or injury occurred. _____							
13. Have you been confined to a hospital for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes", please submit <u>all</u> pages of the Discharge paperwork.							
14. Have you ever had or been treated for the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes", please describe when, where, and by whom. _____ _____ _____							
15. Name and address of hospital(s) and Doctor(s):							
Name		Address			City	State	Zip
_____							
_____							
_____							
16. Last date worked:		17. Date returned to work: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			18. If not returned, date anticipated to return:		
19. Are you currently employed by another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes", please have an additional employer's statement completed by each employer.							
To the best of your knowledge, indicate if you have filed for or are receiving income from any of the following sources:							
Salary Continuance/Sick Leave		<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", indicate number of hours as of last date worked _____				
EIB/PTO		<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", indicate number of hours as of last date worked _____				
	Applied for	Receiving	Amount	Frequency	From/To Dates		
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Dependent Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
No Fault (Income Replacement)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Retirement/Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Permanent Total Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
Other (Please identify) _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____/_____/_____		
The information above is true and correct to the best of my knowledge.							
Claimant's Signature: _____						Date: _____	

**Employer's/Business Entity's Statement**

1. Company Name:		2. Phone Number:	
3. Street Address:	4. City:	5. State:	6. Zip Code:
7. Name of Employee/Insured Person:		8. Social Security #:	
9. Date Employee/Insured Person last worked:		Date of Hire:	
10. Employee's/Insured Person's job title/major job duties <b>(Please attach a copy of job description):</b>			
11. Job Classification: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy		12. Annual Salary:	13. Average hours worked per week:
14. Does this employee/insured person contribute to Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", was the employee hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Is the disability premium paid by the employee/insured person? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", <input type="checkbox"/> Before or <input type="checkbox"/> After taxes	
16. Percentage of the employee/insured person's disability premium you pay:		17. Did disability occur on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Employee's/Insured Person's status as of first day absent: <input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Retired If other than Active, Please explain: _____			
19. If employee was medically cleared to return to work with restrictions or on light duty can you accommodate? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please attach a letter stating why accommodation is not possible.			
20. Date employee/insured person returned to work: _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Light Duty <input type="checkbox"/> Part Time <input type="checkbox"/> Not returned		21. If "Part Time", due to partial disability, provide earnings: Amount: _____ From/To Dates: _____	
22. To the best of your knowledge, indicate if the employee/insured person has filed for or is receiving income from any of the following sources: Salary Continuance/Sick Leave <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate number of hours as of last date worked _____ EIB/PTO <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate number of hours as of last date worked _____ Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. Will employee/insured person earn any future Salary Continuance/Sick Leave/EIB/PTO? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate date: _____			
24. Employee/Insured Person's current status of employment: Date of Hire: _____ <input type="checkbox"/> Active <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Terminated Effective: _____			

The above statements are true and complete to the best of my knowledge and belief.

Employer's/Business Entity's Authorized Representative

Name (please print) \_\_\_\_\_ Title \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return to: Transamerica PO BOX 8043 Little Rock AR 72203-8043  
 Fax 866-224-6547  
 Or to TEBclaimsscanning@transamerica.com

### Attending Physician's Statement

Patient Name: _____	Date of Birth: _____	Social Security No.: _____
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**Instructions:** The following sections must be completed and signed by the attending physician.

**Please complete all applicable sections of this form. In all situations, you must complete the signature block at the bottom of this form.**

**Normal Pregnancy – If unable to work before or after delivery, please attach a letter of medical necessity**

a) Expected Delivery Date: _____ Date first unable to work: _____	b) Actual Delivery Date: _____ Date Hospitalized: _____	c) Delivery Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
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**All Other Conditions**

1. Primary ICD-10: _____ - _____	Diagnosis: _____
Secondary ICD-10: _____ - _____	Diagnosis: _____
Other ICD-10: _____ - _____	Diagnosis: _____

2. Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3. Date symptoms first appeared or accident happened: _____
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4. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when and describe: _____	5. Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Final date of treatment: _____
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6. Initial date of treatment: \_\_\_\_\_ Most recent date of treatment: \_\_\_\_\_

7. Frequency of follow-up:    Weekly    Monthly    Other: \_\_\_\_\_

8. Dates of services since disability commenced: _____ _____ _____	9. Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Admitted: _____ Discharged: _____
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10. Was surgery performed?    Yes    No   If "Yes", CPT 4 code(s): \_\_\_\_\_ Date surgery performed: \_\_\_\_\_

11. Was the patient referred to you?    Yes    No   If "Yes", give the referring physician's name and address.  
Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

12. Has patient reached a point of maximum medical improvement?    Yes    No

13. Did you advise patient to cease work?    Yes    No   If "Yes", From: \_\_\_\_\_ To: \_\_\_\_\_

14. When is the patient expected or estimated to return to work?  
Date of return: \_\_\_\_\_    To regular occupation:    Full Time    Part time    Light duty  
 To any other occupation:    Full Time    Part time    Light duty  
Please describe the patient's prognosis and work/activity restrictions. \_\_\_\_\_  
\_\_\_\_\_

The above statements are true and complete to the best of my knowledge and belief.

Physician's Name (please print) \_\_\_\_\_ Degree: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

<p>FOR RESIDENTS OF <b>ALASKA</b>: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.</p>	<p>FOR RESIDENTS OF <b>NEW HAMPSHIRE</b>: 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 by RSA 638:20.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>ARIZONA</b>: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.</p>	<p>FOR RESIDENTS OF <b>NEW YORK</b>: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>CALIFORNIA</b>: For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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.</p>	<p>FOR RESIDENTS OF <b>NEW JERSEY</b>: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>COLORADO</b>: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.</p>	<p>FOR RESIDENTS OF <b>OHIO</b>: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>DELAWARE, IDAHO, INDIANA</b> or <b>OKLAHOMA</b>: 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.</p>	<p>FOR RESIDENTS OF <b>OREGON</b>: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the mis-information must be material to the content of the policy, the insurer relied upon the mis-information and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>DISTRICT OF COLUMBIA</b> or <b>LOUISIANA</b>: 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 fines and confinement in prison.</p>	<p>FOR RESIDENTS OF <b>PENNSYLVANIA</b>: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 a person to criminal and civil penalties.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>FLORIDA</b>: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.</p>	<p>FOR RESIDENTS OF <b>PUERTO RICO</b>: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than \$5,000 and not more than \$10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>MARYLAND, RHODE ISLAND, TEXAS</b> or <b>WEST VIRGINIA</b>: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>	<p>FOR RESIDENTS OF <b>VIRGINIA</b>: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF <b>MINNESOTA</b>: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</p>	<p>FOR RESIDENTS OF <b>ALL OTHER STATES AND TERRITORIES</b>: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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.</p>
<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p style="text-align: right;">_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>



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**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.
- 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/Insured's Name/Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Insured's SSN \_\_\_\_\_ Patient/Insured's Date of Birth \_\_\_\_\_ Patient/Insured's Phone No. \_\_\_\_\_

Patient/Insured's Address \_\_\_\_\_

Personal Representative's (if any) Name/Signature: \_\_\_\_\_ Personal Representative's Phone No. \_\_\_\_\_

Personal Representative's (if any) Address \_\_\_\_\_

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**



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**Medical  
 Provider  
 List**

**Please Complete and Return This List**

Name of Insured :	Social Security Number :	Policy Number :
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**Please list below the names, addresses, and phone numbers of all medical providers, including doctors and hospitals, consulted or used by you 1 year from the issue date of the policy.**  
 Dates: beginning \_\_\_\_\_ through \_\_\_\_\_

Provider Name	Phone Number	Reason for Visit	
Street Address			Dates consulted or Year treated
City	State	Zip Code	

Provider Name	Phone Number	Reason for Visit	
Street Address			Dates consulted or Year treated
City	State	Zip Code	

Provider Name	Phone Number	Reason for Visit	
Street Address			Dates consulted or Year treated
City	State	Zip Code	

Provider Name	Phone Number	Reason for Visit	
Street Address			Dates consulted or Year treated
City	State	Zip Code	

**The following Prescriptions have been filled (see label on Rx bottle).**

Name/Address of Pharmacy	Doctor	Drug Name	Condition Testing

**\*\*If additional space is needed, please use the other side of this form\*\***

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date