NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

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

Guarantee Trust Life Insurance Company
P.O. Box 1148
Glenview, IL 60025
***For Customer Service, call:* (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/GUARDIAN or Patient– 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 in 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 School Official _____ Title _____

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

9. **Claimant's Social Security Number:** _____
10. **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 # _____

11. Parents Name: Father _____ Mother _____
Employer's Name: _____ _____
Employer's Addr.: _____ _____

Note: Your State Insurance Department requires us to notify you that: 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.

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Student's (or Parent's, if student is a minor) Signature: _____ Print Name_____

Date: ____/____/_____

ATTENDINGS PHYSICIAN'S AND/OR DENTIST'S STATEMENT

IMPORTANT – THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS ACCOMPANIED BY ITEMIZED BILLS INCURRED TO THAT DATE. PLEASE BE CERTAIN THAT ASSIGNMENT SECTION IN THE OTHER SIDE IS COMPLETED IN FULL, IF YOU WISH PAYMENT MADE TO YOUR OFFICE.

1. Name of Patient _____ Alternate Name _____ Age _____ Sex _____
2. Date of Accident _____
3. When, Where and How do You Understand the Injury Occurred? _____
_____
4. Date You First Treated Patient for Injury _____ 20_____ Hour _____ AM PM
5. Nature and Extent of Injuries (state objective findings and describe complications, if any) _____
_____
6. Are There Any Other Contributing Causes, Congenital Conditions, Illnesses or Infirmities? (Describe) _____
_____
7. Patient Hospitalized From _____ 20 _____ To _____ 20_____
8. Name and Address of Hospital _____
9. What Operation or Operative Procedure was performed? Or Nature of Treatment?
_____
What is the Procedure Code Number? _____
If Fracture, Treated by: Reduction Immobilization without Reduction
10. Has Patient Fully Recovered from His/Her Injury? _____
If Not, What Further Treatment, if any, Will be Necessary? _____
11. If Patient was referred to You by Another Physician or Dentist, Please give Name and Address. _____
_____
_
12. Dates Patient Attended _____

PLEASE ATTACH ITEMIZED BILL.

13. To What Other Insuring Organizations are You Reporting These Services? (Please give Name, Address City, St. & Zip)
_____
_
14. What Payments Have Been received or is anticipated from any Other Hospital or Medical Insurance or Plan? _____
_____

SIGNATURE OF PHYSICIAN _____ DEGREE _____ DATE _____

Drs. Taxpayer I.D. or SS # must be completed if benefits assigned. _____

DENTAL INJURY

ANSWER ALL QUESTIONS BELOW**, IN ADDITION TO THOSE ABOVE,** IF DENTISTRY.

1. Identify Teeth Involved in the Accident and Indicate on Chart
_____
_____
2. Describe Exact Nature of Injury _____
_____
3. Nature of Treatment _____
_____
4. Condition of Injured Teeth Prior to Accident
Vital Whole Sound Filled Capped Artificial

1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17
				A	B	C	D	E					F	G	H	I	J
				T	S	R	Q	P					O	N	M	L	K

SIGNATURE OF DENTIST _____ DEGREE _____

ADDRESS _____ 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 (or Parent, if Patient is a minor) and 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 and Date

Social Security Number of Patient_____

Policy Number _____