Transamerica Life Insurance Company ***("insurer")***
Administered by: **Key Benefit Administrators**
P.O. Box 1449, Fort Mill, SC 29716-1449
Phone: 1-866-867-6883 Fax: 1-866-433-5152

TransConnect® Claim Form

To file a claim: Complete Sections 1 and 2. Attach an itemized bill or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized bill attached (if applicable) to the address above with an Explanation of Benefits (EOB) from your primary medical carrier for these specific expenses.

SECTION 1 – EMPLOYEE INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Certificate Number/SSN
4. Address (*include city, state and zip code)*		

5. Phone Number	6. Group Number (6-10 characters) K __ __ __ __ __ __ __ __ __	7. Marital Status: ❐Married ❐Single ❐Other	8. Gender: ❐Male ❐Female

SECTION 2 – PATIENT'S INFORMATION – Please attach an itemized bill: CMS1500 or UB92.

1. Patient's Full Name	2. Date of Birth	3. Relationship to Employee: ❐Self ❐Spouse ❐Child ❐Stepchild ❐Other
4. Date of Accident (if applicable)	5. If auto accident, was patient: ❐Driver ❐Passenger ❐Unknown	6. Is this accident/illness covered by Worker's Compensation? ❐Yes ❐No

7. Date of Service	8. Place of Service (Example: Doctor's Office, Hospital, ER, etc.)	9. Description of Service Performed (Example: X-Ray, lab test, etc.)	10. Reason for Visit (Example: Broken Arm, Flu, etc.)

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT – To be completed by physician only if no itemized bill.

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Transamerica Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

Signature of Patient (If minor, parent/guardian must sign) ______________________ Date __________

If signed on behalf of another, indicate your relationship (Only if patient is unable to sign) ______________________

(Expires six months from this date unless indicated or revoked earlier.)

1. Name and Address of Facility where Services Rendered

2. Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by Reference to Number 1, 2, 3, Etc. or DX Code

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given Procedure Code (Identify)	Explain Unusual Services or Circumstances	D Diagnosis Code	E Charges	F

Your Patient's Account Number	Total Charge	Amount Paid	Balance Due

Physician's Name (please print) ______ Signature ______ Date ______ Tax ID Number or SSN ______

Street Address ______ City ______ State ______ Zip ______ Phone Number ______

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.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

Claimant's signature Date

FOR RESIDENTS OF ARIZONA: 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.

Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: 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.

Claimant's signature Date

FOR RESIDENTS OF COLORADO: 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.

Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA: 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.

Claimant's signature Date

FOR RESIDENTS OF FLORIDA: 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.

Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Claimant's signature Date

FOR RESIDENTS OF LOUISIANA: 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.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

FOR RESIDENTS OF 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 by RSA 638:20.

Claimant's signature Date

FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than $5,000 dollars nor more than $10,000 dollars, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years.

Claimant's signature Date

FOR RESIDENTS OF VIRGINIA, TENNESSEE, MAINE, or DISTRICT OF COLUMBIA: 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.

Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES: 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.

Claimant's signature Date