

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? \_\_\_\_\_

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- 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) \_\_\_\_\_

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- 6. Are There Any Other Contributing Causes, Congenital Conditions, Illnesses or Infirmities? (Describe) \_\_\_\_\_

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- 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. \_\_\_\_\_

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- 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) \_\_\_\_\_

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- 14. What Payments Have Been received or is anticipated from any Other Hospital or Medical Insurance or Plan? \_\_\_\_\_

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**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.

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(Print Please) Name of Patient

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Signature of Patient (or Parent, if Patient is a minor) and Date

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

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Relationship of Authorized Representative or Next of Kin to Patient

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Signature of Authorized Representative or Next of Kin and Date

Social Security Number of Patient \_\_\_\_\_

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