TRANSAMERICA WORKSITE MARKETING

Transamerica Life Insurance Company *("insurer")*
Administered by: Key Benefit Administrators
P.O. Box 1279, Fort Mill, SC 29716-1279
Phone: 1-866-867-6883 Fax: 1-866-433-5152

TransChoice® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of it's rights and defenses

To file a claim: Complete Sections 1 and 2. Attach an itemized statement or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized statement attached (if applicable) to the address above.

SECTION 1 – INSURED'S INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Social Security Number	4. Certificate Number
5. Address (*include city, state and zip code)*			
6. Phone Number	7. Group Number (6-10 characters) _ _ _ _ _ _ _ _ _ _	8. Marital Status: ❒Married ❒Single ❒Other	9. Gender: ❒Male ❒Female

SECTION 2 – PATIENT'S INFORMATION Please attach itemized statement, CMS 1500 or UB92

1. Patient's Full Name	2. Date of Birth	3. Social Security Number
4. Relationship to Insured: ❒Self ❒Spouse ❒Child ❒Stepchild ❒Other	5. Date of Accident (if applicable)	
6. If auto accident, was patient: ❒Driver ❒Passenger ❒Unknown	7. Is this accident/illness covered by Worker's Compensation? ❒Yes ❒No	

If the health care provider is in your PPO network, payment will be made directly to the provider. Any remaining amount up to your indemnity benefit will be paid to you. If the provider is not in your PPO network, payment will be made directly to you.

Please attach an itemized statement: CMS 1500 or UB92 with itemization or have Section 3 completed by the Attending Physician.

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

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. If auto accident, was patient: ❒Driver ❒Passenger ❒Unknown | 3. Is this accident/illness covered by Worker's Compensation? ❒Yes ❒No

4. 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)	C: 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 DISTRICT OF COLUMBIA, LOUISIANA or RHODE ISLAND: 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.

_____
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 MAINE, TENNESSEE or VIRGINIA: 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 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 intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent 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 five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____
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