



National Teachers Associates Life Insurance Company

Attn: Claims Department
P.O. Box 2369 ♦ Addison, TX 75001-2369
(972) 532-2100 ♦ (888) 671-6771
FAX: (972) 532-2192

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR FILING PROOF OF LOSS

1. This form is to be completed by the person or persons to whom the policy is legally payable as beneficiary.
2. If the beneficiary is the insured's estate, the statement should be completed by the executor or administrator and a certified copy of the appointment issued by the proper court and bearing the clerk's signature must be furnished.
3. If the beneficiary is not of legal age, a guardian should complete the form and submit a certified copy of the appointment issued by the proper court and bearing the clerk's signature.
4. **A certified copy of the Official Certificate of Death, certified by the issuing agency, must be supplied to the Company.**
5. Return the original Policy with this form.
6. Please **print or type** all information except signatures.

See page 2 for state specific fraud warnings.

INFORMATION CONCERNING THE INSURED

1. Name (Full Legal) _____
2. Date of Death: (Mo., Day, Year) ____ / ____ / ____ Date of Birth: (Mo., Day, Year) ____ / ____ / ____
3. List all NTA Life insurance policies for which this claim is being made: (Provide all letters and numbers)

All policies listed above must be submitted with your claim. If policies are not attached, please explain why:

4. Names, addresses & phone numbers of all physicians who have treated the insured in the past three (3) years: _____

INFORMATION CONCERNING THE CLAIMANT

1. Name (Full Legal) _____
2. Address: (Include street name & number, city, state & zip)

3. In what capacity are you making this claim? _____
4. Your social security number: _____ - _____ - _____ Your relationship to the deceased: _____
5. Your date of birth: ____ / ____ / ____ Male Female
6. Your phone number (in case we need to contact you):
Daytime () _____ Evening: () _____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize you to give National Teachers Associates Life Insurance Company and/or its reinsurers or its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment and prognosis with respect to any physical or mental condition of the patient; and (b) any non-medical information about the patient which the Company believes it needs to perform the business functions described. This form will be valid for the duration of the claim. I agree that a copy is as valid as the original.

Signature of Beneficiary / Guardian / Executor _____ Date signed: _____

STATE SPECIFIC FRAUD WARNINGS

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

Ohio: 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.

Oklahoma: WARNING: 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.

Oregon: Any person who knowingly and with intent to defraud any insurance company files a statement of claim containing any materially false or misleading information may be guilty of fraud and may be subject to prosecution.

Pennsylvania: 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 person to criminal and civil penalties.

Tennessee: 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.

Texas: 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.

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.



National Teachers Associates Life Insurance Company
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

Authorization for Release of Health-Related Information

This Authorization Complies with HIPAA Privacy Rule

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company
Attn: Director of Compliance
4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

Signature of Individual Whose Information is to be Disclosed

Date

Printed Name of Individual

Policy Number

