



# 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

List Policy Numbers Here


## CLAIMANT'S STATEMENT • WELLNESS BENEFIT • PHYSICIAN CONSULTATION

**Instructions:** For use with our Cancer, Heart Attack/Heart Disease/Stroke, and Disability Income IV Policies. Attach a copy of the statement showing the services provided. If a statement is not available, have the provider complete the Attending Physician's Statement in detail. **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for the payment of 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.

### POLICYHOLDER & PATIENT INFORMATION

NAME OF POLICYHOLDER		SOCIAL SECURITY NUMBER		OCCUPATION		
ADDRESS			CITY		STATE	ZIP
E-MAIL ADDRESS			PHONE DAY ( )		FAX ( )	
			EVENING ( )			
NAME OF PATIENT		PATIENT'S SOCIAL SECURITY NUMBER		RELATIONSHIP TO POLICYHOLDER		PATIENT'S DATE OF BIRTH
						/ /

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, The Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or of any member of my family, or my (our) health, to furnish to National Teachers Associates Life Insurance Company of Addison, Texas or its representative, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. **I represent that the information above is true and correct.**

(Signed) Patient \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Signed) Policyholder \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### ATTENDING PHYSICIAN'S STATEMENT

Please have your physician/provider complete this section to indicate which of the following services were provided for the above-named patient. For Physician Consultation under Disability Income IV Policy, have the licensed medical practitioner you consulted complete this section. (This section does not need to be completed if you are attaching a detailed statement or bill which shows the exact procedure.)

#### For services relating to Cancer Policy:

##### Cancer Screening Procedures

- Mammogram Date: \_\_\_\_\_
- PAP Smear Date: \_\_\_\_\_
- Flexible sigmoidoscopy Date: \_\_\_\_\_
- Chest x-ray Date: \_\_\_\_\_
- Thermography Date: \_\_\_\_\_
- Colonoscopy Date: \_\_\_\_\_
- Blood test for colon cancer Date: \_\_\_\_\_
- Blood test for ovarian cancer Date: \_\_\_\_\_
- Blood test for prostate cancer Date: \_\_\_\_\_

#### For services relating to Heart Attack, Heart Disease and Stroke Policy:

##### Heart Screening and Diagnostic Procedures

- Resting EKG Date: \_\_\_\_\_
- Cardiovascular stress test Date: \_\_\_\_\_
- Lipid profile test Date: \_\_\_\_\_
- Echocardiogram (GRH-1004 series only) Date: \_\_\_\_\_
- Holter Monitor Date: \_\_\_\_\_
- Diagnostic cardiac catheterization Date: \_\_\_\_\_
- Carotid artery scan (GRH-1004 series only) Date: \_\_\_\_\_
- MRI or CT scan (GRH-1004 series only) Date: \_\_\_\_\_
- Outpatient emergency room care for the evaluation of cardiac symptoms Date: \_\_\_\_\_

#### For services relating to Disability Income IV Policy (GRD-6004 series only):

Physician includes any licensed medical practitioner consulted to obtain diagnosis, treatment or medical advice.

Physician Consultation Consultation Date: \_\_\_\_\_

SIGNATURE OF PHYSICIAN *		PHYSICIAN'S FEDERAL I.D. NUMBER OR SOCIAL SECURITY NUMBER		PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE	
SIGNED		DATE		TELEPHONE NUMBER:	
PRINT PHYSICIAN'S NAME		PATIENT'S ACCOUNT NUMBER		FAX NUMBER:	



**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, Pharmacy Benefit Managers and other medically related facilities) to disclose all medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) and all pharmacy records 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



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