NTA Life®
a Horace Mann company

NTA LIFE CLAIM PACKET

ONLINE CLAIM SUBMISSION IS NOW AVAILABLE
Submit claims online through your MyNTALife account!

Included in this packet you will find:

1. *Wellness Benefit Claim Form*
2. *Authorization for the Release of Health-Related Information Form*

Direct Deposit: Receive claim payments faster

- **Fast and Convenient**
  Claims payments are deposited directly into your account. No more waiting by the mailbox or driving to the bank.
- **Sign Up Today**
  Simply complete the *Direct Deposit/ACH Agreement* form in the "Forms" section of ntalife.com and submit with your claim forms. We will do the rest. It's that easy!
- **Already Signed Up?**
  You don't have to do a thing. We will use your most recent election or you can make changes to your preferences through your MyNTALife account.

MyNTALife: Access and convenience in one place

Start experiencing the benefits of a **MyNTALife** account today:

- **Fast** and **convenient** access
- **Pay** premiums
- File and manage **Claims**
- Update your **Profile** and **Communication** delivery **Preferences**
- Manage **Direct Deposit** elections

and more…

Visit us at **ntalife.com** and register for your account today!

THANK YOU FOR CHOOSING NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY!

Questions? We're here to help.
888.671.6771

NTA Life
a Horace Mann company

National Teachers Associates Life Insurance Company

WELLNESS BENEFIT CLAIM FORM

Customer Service Center 1-888-671-6771
ntalife.com

Instructions: Complete this form to file a claim for wellness, screening, diagnostic, physician consultation or similar benefits under a Cancer; Heart Attack, Heart Disease & Stroke; or Disability Income Policy. If available, please provide a copy of the statement or bill showing the service provided. The completed form should be signed and returned using the contact information at the bottom of the form.

LIST YOUR POLICY NUMBER(S) HERE:

POLICY #	POLICY #	POLICY #	POLICY #

Policyowner Information

NAME OF POLICYOWNER	SOCIAL SECURITY NUMBER	OCCUPATION
	- -	

ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS ☐ I would like to receive electronic correspondence concerning my claims and policies.

PHONE
Home ( ) - Mobile ( ) - Work ( ) -

Patient Information

NAME OF PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH
	- -	/ /

PHONE	RELATIONSHIP TO POLICYHOLDER	HEIGHT	WEIGHT
( ) -	○ Policyowner ○ Spouse ○ Dependent	ft. in.	lbs.

Provider Information

NAME OF PROVIDER/PHYSICIAN	PHONE	FAX
	( ) -	( ) -

PROVIDER ADDRESS	CITY	STATE	ZIP

Claim Information

Please complete this section to indicate the nature of the services received by the above named patient. Procedures listed below may not be covered under all policies and some policies may not include wellness, physician consultation or similar benefits. In some circumstances, additional information may be requested as proof of loss documentation for benefits under the policy. For procedures not listed, please check "Other" and describe the procedure performed in the space provided or provide the wellness screening report or physician consultation's office note.

Cancer Policy Wellness Screening Benefit

- ☐ 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: / /
- ☐ Biopsy not resulting in cancer diagnosis Date: / /
- ☐ Other_____ Date: / /

Heart Attack, Heart Disease and Stroke Policy Wellness Screening Benefit

- ☐ Resting EKG Date: / /
- ☐ Cardiovascular stress test Date: / /
- ☐ Lipid profile test Date: / /
- ☐ Echocardiogram Date: / /
- ☐ Holter Monitor Date: / /
- ☐ Diagnostic cardiac catheterization Date: / /
- ☐ Carotid artery scan Date: / /
- ☐ MRI or CT scan Date: / /
- ☐ Outpatient emergency room care for evaluation of cardiac symptoms Date: / /
- ☐ Other_____ Date: / /

Disability Income Policy Physician Consultation Benefit

See your policy for more information on Physician consultation benefits and definitions.

☐ Physician Consultation Reason for Consultation_____ Consultation Date: _____

By signing below, I represent that all information on this form is true and correct and that I have read the state-specific fraud warning on the following page.

(Signed) Patient _____ Date _____/_____/_____
A parent or legal guardian must sign if the patient is under the age of 18.

(Signed) Policyowner _____ Date _____/_____/_____

SEND THIS COMPLETED FORM TO THE CLAIMS PROCESSING CENTER BY:
EMAIL: Wellness@NTALife.com **FAX:** 1-855-512-5247 **MAIL:** P.O. Box 2369 Addison, TX 75001-2369

STATE-SPECIFIC FRAUD WARNINGS

Please review the following fraud warning for your state before signing the Claimant Statement on the previous page.

The following Fraud Warning applies to these states: **Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, Wisconsin, Wyoming and West Virginia.**

Warning: 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 or confinement in prison.

California-Warning: 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.

Colorado-Warning: 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 damage. 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 insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida-Warning: 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.

Kansas-Warning: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky-Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine-Warning: 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 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.

Maryland-Warning: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire-Warning: 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 in RSA 638:20.

New Jersey-Warning: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico-Warning: 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-Warning: 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.

Pennsylvania-Warning: 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 & Washington-Warning: 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-Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

Virginia-Warning: Any person who, with the 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 may have violated state law.

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, other medically related facilities, other insurance companies, and MIB, Inc.) 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 ("NTA Life") and affiliated entities (including its reinsurers) 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.

NTA Life 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 also, authorize NTA Life, or its reinsurers, to make a brief report of my protected health information to MIB.

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
P.O. Box 802207 • Dallas, Texas 75380

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