



Transamerica Life Insurance Company
P.O. Box 219 Cedar Rapids, IA 52406-0219
Claims fax: 866-224-6547
Claims email: TEBclaimsscanning@transamerica.com
Claims customer service: 800-251-7254

TransConnect® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or 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 with an Explanation of Benefits (EOB) from your primary medical carrier for these specific expenses.

SECTION 1 – EMPLOYEE INFORMATION		
1. Insured's Full Name	2. Date of Birth	3. Certificate Number/SSN
4a. Mailing Address (include city, state and zip code)		5. Phone Number
4b. Street Address (include city, state and zip code)		6. Email Address

SECTION 2 – PATIENT'S INFORMATION – Please attach an itemized statement: CMS1500 or UB04.			
1. Patient's Full Name		2. Date of Birth	3. Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other
4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social Security Number	6. Date of Accident (If applicable)	7. If auto accident, was patient: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Unknown
8. Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Date of Service	10. Place of Service (Example: Doctor's Office, Hospital, ER, etc.)	11. Description of Services Performed (Example: x-ray, lab test, etc.)
12. Reason for Visit (Example: Broken Arm, Flu, etc.)		13. Provider's Name and Address	
14. Benefits will be paid directly to you unless you instruct us to pay the provider. <input type="checkbox"/> Pay benefits to the provider <input type="checkbox"/> Pay benefits to me			

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT – To be completed by physician only if no itemized statement. EDI Payer 75261	
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. Diagnosis or Nature of Illness or Injury. <u>Relate Diagnosis Code in D to Procedure Code in C</u>						
A	B	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given		D	E	F
Date of Service	Place of Service	Procedure Code (Identify)	Explain Unusual Services or Circumstances	Diagnosis Code	Charges	
					⋮	
SEE ATTACHED						
					⋮	
Patient's Account Number				Total Charge	Amount Paid	Balance Due
				⋮	⋮	⋮

Physician's Name (please print)	Signature	Date	Tax ID Number or SSN
Mailing 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.

<p>FOR RESIDENTS OF ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.</p>	<p>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.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>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.</p>	<p>FOR RESIDENTS OF NEW YORK: 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>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.</p>	<p>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.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>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.</p>	<p>FOR RESIDENTS OF 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.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA: 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.</p>	<p>FOR RESIDENTS OF OREGON: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the mis-information must be material to the content of the policy, the insurer relied upon the mis-information and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF DISTRICT OF COLUMBIA or LOUISIANA: 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.</p>	<p>FOR RESIDENTS OF 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 a person to criminal and civil penalties.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>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.</p>	<p>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 payment of a loss or any other benefit, or presents more than one 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 \$5,000 and not more than \$10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF MARYLAND, RHODE ISLAND, TEXAS or WEST VIRGINIA: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>	<p>FOR RESIDENTS OF VIRGINIA: 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 the state law.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>
<p>FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</p>	<p>FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: 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.</p>
<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>	<p>_____ Claimant's signature</p> <p style="text-align: right;">_____ Date</p>