Transamerica Premier Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499
1-800-638-3080 /**F ax: 410-385-5971**

****Submit This Completed Form With a Death Certificate for The Deceased Insured and the Original Policies****

Section A- Deceased's Information

Policy Numbers_____

_____

_____

Deceased's Name_____

Any Previous Name_____

Social Security No._____

Deceased's Date of Death_____

Deceased's Date of Birth_____

Deceased's Address_____

_____

Section B- Your Information

Name of Claimant_____

Your Social Security No._____

Are you a US Citizen/Resident Alien? **YES** **NO**

If no, of what Country are you a citizen?_____

Mailing Address_____

_____

Daytime Telephone_____

Email Address_____

Relationship to Deceased _____

Date of Birth _____ Age_____

I certify under penalties of perjury that I am a US Citizen or resident alien, that the number shown on this form is my correct taxpayer ID, and that I am not subject to back-up withholding. I attest that if an insurance policy has not been submitted with this claim,the policy has been lost or destroyed. I have read the applicable fraud warning statement which accompanied this form.

Signature_____ **Date**_____

Section C- Information We Need From You to Process Your Claim

Name of Funeral Home handling burial_____

Funeral Home Address_____

Funeral Home Telephone Number_____ Funeral Home Tax ID Number _____

Louisiana Residents Only - Will the proceeds be used to fund a preneed funeral contract? **YES** **NO**
If yes, a certified death certificate is required

If you did not attach a Certified Death Certificate, circle the manner of death below:

NATURAL ACCIDENTAL HOMICIDE SUICIDE PENDING INVESTIGATION

Section D- Deceased's Medical Providers

Provide the Name, Address, and Phone Number of all medical providers who treated the deceased during the last five years.

Provider's Name **Address** **Phone Number**

_____

_____

*****MAIL OR FAX ALL CLAIM DOCUMENTS TO THE ADDRESS OR FAX NUMBER ABOVE*****

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule
A copy of this authorization will be considered as valid as the original

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, long term care facilities (including assisted living facilities), home health care entities and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the **entire medical record** and any other protected health information concerning the insured/patient to the company(ies) referenced at the top of this authorization (the "Companies"), their affiliates and reinsurers, and any business associate, agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency (including MIB, Inc. formerly known as the Medical Information Bureau) or independent claim administrator acting on behalf of any of the Companies. This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, diagnosis, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), prescription drug information, substance abuse records, medical records, medical notes, and medical recordings. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization and I instruct the Providers to release and disclose the **entire medical record and any other protected health information as noted above** without restriction.

The information disclosed will be used for claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations.

This authorization shall remain in force for 24 months, or in the case of long term care or disability claims for the duration of the claims under such policy, following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Consumer Affairs Department, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies. I understand that I have a right to receive the Notice of Health Information Privacy Practices upon request.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the **entire medical record** of the insured/patient, the Companies may not be able to proceed with claims or eligibility processing or make any benefit payments. I acknowledge that (1) if I am signing on behalf of the insured/patient, I am legally permitted to do so as the personal representative of the insured/patient, and (2) I have received a copy of this authorization.

_____ _____
Name of insured/patient (please print) Date of birth

_____ _____
Signature of Insured/Patient or Personal Representative of the Insured/Patient Date

_____
Description of Personal Representative's Authority or Relationship to Insured/Patient

_____
Policy or Contract Number

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