



MONTEBELLO UNIFIED SCHOOL DISTRICT

Mark Skvarna, Interim Superintendent of Schools
123 South Montebello Blvd., Montebello, CA 90640
(323) 887-7900 • (562) 806-7900

STUDENT ACCIDENT INSURANCE / HEALTH INSURANCE **2023-2024 School Year**

Dear Parents:

The Montebello Unified School District does not provide medical, accident or dental insurance for pupils injured on school premises or through school activities. In accordance with Education Code Section 49472, the District is making available a low cost medical/dental accident insurance program.

Accident Only Plans

The purpose of these plans is to provide assistance at a minimum cost to meet some of the expenses for accidental injury. The plans pay the first \$500.00 in benefits in addition to other insurance, which can help you meet your primary insurance deductibles and/or co-payments.

The plan costs are in the chart below. Please visit your Childs' School Office to obtain a detailed brochure/application, or you may obtain one and sign up online at www.peinsurance.com (click on Products, then Student Insurance). **Please read the Student Benefits Plan Brochure to select the plan that best meets your needs.**

All Plans Are A **ONE TIME ANNUAL** Payment

<i>Options</i>	<i>Low</i>	<i>High</i>
At School Plan		
Grades P-8	\$11.00	\$25.00
Grades 9-12	\$24.00	\$54.00
24-Hr-a-Day Plan		
Grades P-8	\$75.00	\$161.00
Grades 9-12	\$92.00	\$192.00
Optional Tackle Football Coverage		
Grade 9	\$36.00	\$80.00
Grades 10-12	\$84.00	\$177.00

Please see brochure for complete plan details

BOARD OF EDUCATION

ELIZABETH CABRERA, *President*
LILIANA MAGANA, *Vice President*
JENNIFER GUTIERREZ, *Clerk*
MARISOL MADRIGAL URIBE, *Member*
CARLOS CERDAN, *Member*

Health Insurance Plans

Pacific Educators can also assist people in applying for regular health insurance plans. Some may **qualify for tax savings and government assistance**. We will be happy to help you get all the potential assistance/subsidies you are eligible for. Please call the number below or visit our website at www.peinsurance.com click 'products' and then 'health insurance'.

Since the district does **NOT** provide medical/dental accident insurance, we urge that serious consideration be given to these programs. If you have further questions, please call Pacific Educators, Inc., at (800) 722-3365 or (714) 639-0962.

Mark Skvarna
Superintendent of Schools



BOARD OF EDUCATION

ELIZABETH CABRERA, *President*
LILIANA MAGANA, *Vice President*
JENNIFER GUTIERREZ, *Clerk*
MARISOL MADRIGAL URIBE, *Member*
CARLOS CERDAN, *Member*



- Please note that there are four pages to the brochure (not including this one)
- You may apply online with a credit card here <https://www.peinsurance.com/signup/> OR:
- If you would like to apply with a paper application, the third page below is an actual application that you can print and complete by hand, **or you may complete on computer and print.** DO NOT SEND CASH. Make check or money order payable to Pacific Educators and mail to:
 - **Pacific Educators**
2808 E. Katella Ave., Suite 101
Orange, CA 92867
- The last page is a **FREE Prescription Drug Card Program** you can print and take to a Pharmacy to help anyone lower their prescription drug costs.
- If you have any questions, please do not hesitate to contact us directly (800) 722-3365 or email at applications@peinsurance.com

2023-2024 STUDENT ACCIDENT INSURANCE PLANS

WE RECOMMEND 24-HOUR-A-DAY COVERAGE

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital charges.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL) or its representative (but not prior to the opening day of school).
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

OPTIONAL FOOTBALL COVERAGE BEGINS ON THE DATE OF PREMIUM RECEIPT BY GTL, ITS REPRESENTATIVES OR SCHOOL OFFICIALS, BUT NOT PRIOR TO THE FIRST OFFICIAL DATE OF PRACTICE; AND CONTINUES THROUGH THE DATE OF THE LAST OFFICIAL GAME OF THE CURRENT SEASON INCLUDING PLAYOFFS.

To file a claim: Report accidents to the school official. Simplified forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Completed proof of loss and accumulated bills must be received by GTL within 90 days.

24-HOUR-A-DAY ACCIDENT COVERAGE

24-Hour-A-Day Protection for each Covered Accident

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

- 📍 At home 📍 At play 📍 At school 📍 On vacation 📍 Scouting, camping etc. 📍 During covered travel
- 📍 While engaged in sports, except those specifically excluded or for which optional coverage is required*

***See OPTIONS for available optional sports coverage, if any.**

SCHOOL-TIME ACCIDENT COVERAGE

Helps protect your child while attending regular school sessions. Includes coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

EXCESS PROVISION: All Covered Charges over \$500 will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance or Plan covers the Insured person. GTL will pay the first \$500 in Covered Charges regardless of other insurance.

This is an illustration of your child's benefits. Please keep for your records. This is not a contract. The Master Policy is on file with your school.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

What's Covered? Up to \$50,000.00 as described under Benefits Per Injury for:

- Accidents occurring while coverage is in force. ■ Loss from accidental bodily Injury resulting directly and independently of all other causes. ■ Covered medical charges which begin within 120 days of the Accident and are incurred within 52 weeks of the date of first medical treatment.

Your school district does not carry medical or dental insurance for your child should he/she be injured on school premises while under school grounds jurisdiction, or through school sponsored activities. However it does make this plan available to you, for your consideration.

Esto es para avisarle que su Distrito de la Escuela no tiene aseguranza medica ni dental para su nino/nina si se lastima en el terreno de la escuela aunque haiga supervisor en las actividades. Pero se puede tener un plan para su consideracion. Este plan de aseguranza es voluntario. Usted debe saber que la ley del estado requiere cualquier estudiante que participe en deportes escolares debe tener aseguranza adecuada para medico antes de paticipar en deportes.

BENEFITS PER INJURY - PAYABLE UP TO THE DOLLAR AMOUNTS SPECIFIED BELOW	HIGH OPTION	LOW OPTION
HOSPITAL & GENERAL NURSING CARE - Room and board per day, semi-private room rate.....	100% of R&C*	\$300
- Intensive Care, per day.....	\$1,200	\$600
INPATIENT AND OUTPATIENT HOSPITAL MISCELLANEOUS CHARGES	\$3,000	\$1,500
HOSPITAL EMERGENCY CARE , excluding professional charges.....	\$300	\$150
DOCTOR'S CHARGES FOR SURGERY , in accordance with the surgical schedule.....	\$270	\$175
	Unit Value	Unit Value
ADMINISTRATION OF ANESTHESIA , percent of surgical schedule allowance.....	25%	25%
ASSISTANT SURGEON CHARGE , percent of surgical schedule allowance.....	25%	25%
OUTPATIENT NON-SURGICAL DOCTOR'S VISITS , including Physical Therapy, limited to one visit per day; Physical Therapy is limited to 9 visits		
- First visit	\$120	\$60
- Each visit thereafter.....	\$60	\$30
DURABLE MEDICAL EQUIPMENT , including orthopedic appliances.....	\$100	\$50
AMBULANCE CHARGES	100% of R&C*	\$250
OUTPATIENT X-RAY SERVICES	\$500	\$250
OUTPATIENT IMAGING PROCEDURES , including interpretation for MRI/CAT Scan.....	\$900	\$500
PRESCRIPTION DRUGS	100% of R&C*	\$50
DENTAL TREATMENT , for Injury to Sound Natural Teeth, per tooth.....	\$300	\$150
EYEGLASS REPLACEMENT EXPENSE , for broken eyeglasses, lenses or contact lenses resulting from an Injury requiring medical treatment.....	\$150	\$100
RE-AGGRAVATION OR RE-INJURY OF A PRE-EXISTING CONDITION	\$500	\$500
<u>For the benefits shown below only one of the amounts, the largest, will be paid for loss resulting from any one Accident</u>		
ACCIDENTAL DEATH , caused by an Injury and occurring within 365 days of covered Accident.....	\$5,000	\$5,000
ACCIDENTAL DISMEMBERMENT , caused by an Injury and occurring within 365 days of covered Accident		
- Loss of one hand, one foot or one eye.....	\$5,000	\$5,000
- Loss of hands, feet or eyes.....	\$10,000	\$10,000

***The Policy provides benefits for Reasonable and Customary (R&C) charges determined by geographic area for Medically Necessary services.**

EXTENDED DENTAL BENEFIT OPTION: For an additional premium the Dental Treatment Benefit will be increased to pay all Reasonable and Customary charges for: examination, diagnoses and x-ray; restorative treatment; endodontics; and oral surgery (not to include periodontics or orthodontics); up to \$250 for dental prostheses toward the cost of a bridge, partial denture or denture, or for replacement in kind of previous dental repairs. If during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, GTL will pay up to a maximum of \$100 in lieu of all other dental benefits.

EXCLUSIONS: The Policy does not provide benefits for: 1. Treatment, services or supplies which: are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are determined to be Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy; 2. Intentionally self-inflicted Injury; 3. Injury received while violating or attempting to violate any duly enacted law; 4. Injury by acts of war, whether declared or not; 5. Injury covered by Workers' Compensation or the Occupational Disease Law; 6. Heat exhaustion or heat stroke; 7. Hernia or slipped femoral capital epiphysis; 8. Injury sustained fighting or brawling, except as an innocent victim; 9. Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four- wheeled recreational motor/engine driven vehicle or snowmobile or all-terrain vehicle (ATV); 10. Injury sustained while by participating in or practicing for Interscholastic tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased; 11. Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance; 12. Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; 13. Charges for treatments, services or supplies which exceed reasonable and customary charges; 14. Losses directly or indirectly arising out of any chemical or biological release and/or contamination which results from Terrorist Activity; 15. Any loss as the result of Terrorist Activity and/or non-detonating weapons of mass destruction; or 16. Any loss directly or indirectly arising out of any nuclear explosion, detonation, release and/or contamination whether in time of peace or war, and regardless of any other causes or events contributing concurrently or in any other sequence thereto.

Administered by: **PACIFIC EDUCATORS, INC.**, 2808 E. Katella Ave., Suite 101, Orange, CA 92867-5299

(714) 639-0962 or (800) 722-3365 - Pacific Educators' California License No. 0429928

Underwritten and Claims Paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**, Glenview IL - (800) 622-1993

2023-24 SCHOOL YEAR ENROLLMENT FORM

ONE TIME ANNUAL PAYMENT		
OPTIONS	HIGH OPTION	LOW OPTION
24-HOUR-A-DAY PLAN \$50,000 Maximum per Injury Grades Pre-K thru 8 Grades 9 thru 12	<input type="checkbox"/> \$161 <input type="checkbox"/> \$192	<input type="checkbox"/> \$75 <input type="checkbox"/> \$92
SCHOOL-TIME PLAN Maximum per Injury: \$50,000 for High Option \$25,000 for Low Option Grades Pre-K thru 8 Grades 9 thru 12	<input type="checkbox"/> \$25 <input type="checkbox"/> \$54	<input type="checkbox"/> \$11 <input type="checkbox"/> \$24
OPTIONAL FOOTBALL COVERAGE (2023 Season Only) Payable in addition to School-Time & 24-Hour \$25,000 Maximum per Injury Grade 9 Grades 10 thru 12	<input type="checkbox"/> \$80 <input type="checkbox"/> \$177	<input type="checkbox"/> \$36 <input type="checkbox"/> \$84
EXTENDED DENTAL OPTION <input type="checkbox"/> \$6		
TOTAL \$ _____ (Please do not send cash) MAKE CHECK PAYABLE TO: PACIFIC EDUCATORS, INC.		
NO REFUNDS ARE AVAILABLE		

PLEASE PRINT CLEARLY

GTL | GUARANTEE TRUST LIFE

STUDENT'S NAME _____
 FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH _____ MONTH _____ DAY _____ YEAR _____ MALE ☐ FEMALE ☐

SCHOOL DISTRICT _____ SCHOOL _____

GRADE _____ STUDENT'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____ DATE OF ENROLLMENT _____

PARENT OR GUARDIAN'S EMAIL ADDRESS _____

NAME OF PARENT OR GUARDIAN (PLEASE PRINT) _____

SIGNATURE OF PARENT OR GUARDIAN _____

GA-15-KEF

TO PAY BY CREDIT/DEBIT CARD (fee applies) PLEASE GO TO:
WWW.PEINSURANCE.COM OR CALL (800) 722-3365

PLEASE REMEMBER TO:



COMPLETE THE ENROLLMENT FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.



MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE ENROLLMENT FORM WITH YOUR CHECK OR MONEY ORDER TO:






Pacific Educators, Inc.
2808 E. Katella Ave., Suite 101
Orange, CA 92867-5299



PLEASE NOTE: YOUR CANCELED CHECK IS YOUR RECEIPT. IF CANCELED CHECK IS NOT RECEIVED WITHIN 60 DAYS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR.

For faster service you can pay by credit or debit card (fee applies) please visit us online at:

Pacific Educators
www.peinsurance.com
click Products then Students
or call (800) 722-3365

<div style="text-align: center;">  <p>Pacific Educators FREE Prescription Drug Card</p> </div> <p>Member: California Student ID Number: 26291W22ES Program: UNARxCard RxBIN: 610709 RxGrp: PFCEDU</p> <p>Note: Everyone is eligible for this program. There are no age or income restrictions. Each family member must have his/her own card. If you can't print a card have your pharmacy call the Pharmacy Help Line and we will help them process your prescription.</p> <p style="text-align: center;">THIS PROGRAM IS NOT INSURANCE THIS PROGRAM IS A POINT OF SALE DISCOUNT PLAN</p>	<p>INSTRUCTIONS This card is pre-activated and can be used immediately. Simply print this card and take to any participating pharmacy to receive a discount. You can search pharmacy, pricing information, and FAQ's on the website. We are restricted from disclosing drug pricing over the phone. Customer Service (TOLL FREE) 800-726-4232</p> <p>ATTENTION PHARMACIST If you need help processing a prescription call our Pharmacy Help Line at Pharmacy Help Line (TOLL FREE) 877-321-6755.</p> <p>PROGRAM POWERED BY:</p> <div style="text-align: center;">   </div> <p style="text-align: center;">© Copyright 2010 United Networks of America</p>
---	--

IMPORTANT: PRINT CARD. YOU WILL NEED TO BRING THIS CARD TO THE PHARMACY WITH YOUR PRESCRIPTION.

We are proud to announce that Pacific Educators is now making available a **FREE Prescription Drug Card Program** to help anyone lower their prescription drug costs.

This card can be used with a primary plan and/or on prescriptions not covered by your insurance plan. It also can be used even if you don't have any insurance. The Rx Card Program has no restrictions or participation requirements and is open to anyone.

This Free Prescription Drug Card is pre-activated and can be used immediately.



NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the School or School District **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Policy Number on the claim form. Also, the "HIPPA Authorization To Permit Use and Disclosure of Health Information" must be signed.
- **PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED WITHIN 90 DAYS OF THE ACCIDENT. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED WITHIN 90 DAYS OF TREATMENT.**
- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
 - 1) **The date(s) of treatment,**
 - 2) **The type(s) of service,**
 - 3) **The diagnosis,**
 - 4) **The medical provider's name and address**
 - 5) **The individual charge for each expense.**
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.
- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

**GUARANTEE TRUST LIFE INSURANCE COMPANY
P.O. Box 1148
Glenview, Illinois 60025**

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, School or School District Name, Policy Number, and date of accident.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please take note that your claim will result in processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at (800) 622-1993.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS
INFORMATION MUST BE GIVEN
OR CLAIM WILL BE RETURNED

GUARANTEE TRUST LIFE INS. CO.
P.O. Box 1148
Glenview, IL 60025
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: _____ Hosp.: _____ Other: _____
Addr: _____ Addr: _____ Addr: _____
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or
Other Payee indicated above.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____
Claimant – if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. Claimant's FULL NAME _____ Alternate Name _____ Date of Birth ____/____/____ Grade _____
2. Claimant's Address: Street or RFD _____ City _____ State _____ Zip _____
3. Date of Accident _____ 20____ Hour _____ AM ☐ PM ☐
4. Description of Accident: (A) How and where did it occur? _____
(if more space needed, attach separate sheet)
(B) Nature of Injury _____
5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ Intramural ☐ Interscholastic ☐ Other ☐
6. (A) On date of accident what time did school start for this student? _____ AM ☐ PM ☐
(B) What time was student dismissed from school? _____ AM ☐ PM ☐
7. Has a previous claim been filed for this accident? Yes ☐ No ☐
8. (A) Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? Yes ☐ No ☐
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary ☐ Jr. High ☐ High ☐ Other ☐

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. Do you have other insurance, which covers this condition, either group, individual, automobile medical or liability? Yes ☐ No ☐
If Yes, give Company Name and Phone Number _____ Policy # _____
10. Parents Name: Father _____ Mother _____
Employer's Name: _____
Employer's Address: _____

I certify that the above information is correct to the best of my knowledge and belief.

SIGNATURE _____ DATE _____ ADDR _____
(Parent/Guardian or claimant if an Adult)

For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator located at the facility named below to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

Facility Name: _____

Address: _____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Patient

Date of Birth

Signature of Patient

Date

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin

Date