TRANSAMERICA LIFE INSURANCE COMPANY

TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY

Filing a Long Term Care Claim

What to expect during the long term care claim process

Transamerica®

We realize you and your family are going through a time where some difficult decisions may need to be made. We're here to help make the process easier. This brochure outlines the steps involved when filing a Long Term Care insurance claim and provides answers to the most common questions.

Your doctor or other medical professional will assist you in determining the services that are appropriate for your long term care needs. Your Transamerica Long Term Care policy outlines the benefits, services, and types of care that are covered.

STEPS TO FILING A CLAIM

1 Contact us as soon as possible.

Once you have determined Long Term Care services are needed, it is imperative you contact us immediately to initiate a claim.

Contact a Claims Specialist in our Claims Customer Service Department at:
866-745-3545
Monday – Friday 8:00 a.m. to 5:30 p.m. Central Time

2 Complete documentation.

A claim form packet will be sent to you or your representative, which will contain:

- **A HIPAA authorization for the Release of Medical Records**
  This form allows care providers to release pertinent information directly to us to expedite review of the claim.
- **Authorization for the Release of Information to Family Members & Other Individuals**
  (also referred to as the "Friends and Family Form") — if applicable. This form allows us to discuss the claim with designated representatives.
- **A Questionnaire** about the claimant, any designated contact people, and all care providers.

The documents listed above must be completed, signed, and dated by the insured or their legal representative.

» **Power of Attorney** (POA) — if applicable. If the insured wishes to have someone act on their behalf and manage their insurance affairs, we will need to have a valid copy of the POA papers on file with us. You may wish to seek legal advice to ensure you have the appropriate type of POA in place.

3 Receive assistance from a Care Coordinator.

To help guide you through the long term care process, a Care Coordination Agency will be assigned to assist you with:

- **Gathering the documentation needed** for us to determine the eligibility of both the insured and the service or care provider they have selected. This documentation is dependent upon factors such as the insured's condition, policy, or state requirements.
- **Scheduling and conducting an on-site assessment** — the insured will be asked to meet with a medical professional (usually a licensed nurse) to assess their needs for services. This assessment is usually conducted in the home or the facility where they are currently residing.
- **Obtaining a list of service providers** in your area, if necessary, such as nursing facilities, adult day care, visiting nurse associations, and community outreach.

  The Care Coordinator won't suggest or recommend any provider, but will establish a starting point for the insured and loved ones to find the right solution.

FREQUENTLY ASKED QUESTIONS

What are the requirements for Claims Reimbursement?

- Eligibility criteria has been met and the claim has been approved; and,
- The Elimination Period has been met; and,
- Itemized Billing Statements have been submitted.

If the policy has an Elimination Period how does it impact the claim?

- The Elimination Period must be met before any Long Term Care policy benefits can be paid.
  - » An Elimination Period is the time during which no benefits are payable (similar to a deductible, but measured in days). For example, if the policy Elimination Period is 90 days, the expenses incurred for the first 90 days of services received are the responsibility of the insured.
  - » These dates of services are applied towards the Elimination Period as long as the services have already been rendered.

What do Itemized Billing Statements include?

- The name of the insured.
- Policy number.
- Name of the provider of service.
- The dates/times of the service and the associated charges (hourly or daily).
  - » If there are days during the billing period when services are not received, these dates will need to be indicated on the itemized billing statement.
- The bill must be on the provider's letterhead.

When can bills be submitted?

Note: Most facilities will bill for their services ***in advance***. Services must be rendered before benefits can be considered for payment. Billing statements submitted in advance of the service being rendered will have to be resubmitted.

We understand that you may still have questions about your claim. If so, please contact us at:

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