Trustmark
Voluntary Benefit Solutions®
PERSONAL. FLEXIBLE. TRUSTED.
100 NORTH PARKWAY, SUITE 200 • WORCESTER, MA 01605 • 1-800-918-8877 • FAX 1-508-853-2867
www.trustmarksolutions.com

ACCIDENT CLAIM FORM

This form must be completed by the attending physician and the policy owner and be returned to us for consideration of benefits. If you are claiming under the Accident Disability Benefit, the Employer section must be completed. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please keep a copy of this form and any attachments for your records.

The policy owner is responsible for completion of all portions of this form without expense to Trustmark Insurance Company.

FRAUD NOTICE: Any person who knowingly and with intent to defraud an insurer files an application or a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

INSTRUCTIONS:

Section A & B: These sections must be completed by you, the policy owner.
Section C: This section must be completed by the physician who is treating you for this disability/accident.
Section D: This section must be completed by your employer if you are filing a claim for the Accident Disability Benefit.
State Required Fraud Language: Attached for your information.
Disclosure Authorization: You must sign and date this form. Provide a copy of the signed and dated form to your attending physician.
Insured Statement of Claim - Communication: Complete only if you would like us to communicate with you by email **OR** if you would like us to discuss, release or provide information to others you designate regarding your claim."
Please enclose any additional information that you feel will assist Trustmark in evaluating this claim.

SECTION A:

Policy/Certificate #: _____ Policy Owner Name: _____

Patient's Name: _____ DOB: _____

Relationship to Policy Owner: ☐ Spouse ☐ Child ☐ Self ☐ Other

Policy Owner Address: _____
Street City State ZIP Code

Policy Owner Home Phone: _____ Policy Owner Work Phone: _____

Policy Owner Date of Birth: _____ Policy Owner Social Security #: _____

Policy Owner Employer's Name: _____

SECTION B: POLICY OWNER'S STATEMENT

Please complete below and attach itemized copies of any related bills, including doctor, emergency room, hospital and motor vehicle incident/accident report. Bills should include diagnosis information from your medical provider.

Date of accident: _____ Date of first treatment for the accident: _____

Please provide a description of where the accident occurred and what happened to you.

Primary Care Physician: _____ Phone No. of Primary Care Physician: _____

_____
Street City State Zip Code

Were you confined to a hospital? ☐ Yes ☐ No If yes, please provide the following:

Name of Hospital: _____ Phone No. of Hospital: _____

_____
Street City State Zip Code

Dates of Hospitalization: _____

The statements made by me on this claim are true and complete. I have read and understand the fraud notices contained in this claim form.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of Claimant _____ Please Print Name _____

I signed on behalf of the claimant, as _____ (relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**

Date Signed _____

SECTION C: ATTENDING PHYSICIAN STATEMENT

ICD -9 Code: _____ Diagnosis: _____

Was this condition the result of an accident? ☐ Yes ☐ No If yes, was the accident work related? ☐ Yes ☐ No

Was the patient hospital confined? ☐ Yes ☐ No If yes, dates of confinement: _____

During confinement was the patient in intensive care or coronary care unit? ☐ Yes ☐ No If so, dates of confinement: _____

Hospital Name: _____ Hospital Address: _____

If the condition was a fracture, was it an avulsion/chip fracture? ☐ Yes ☐ No

If the condition was a fracture or dislocation, was it an: ☐ Open Injury ☐ Closed Injury

If the condition involved laceration(s), what is the length of each laceration? _____

If the condition was a burn, please indicate: ☐ Second Degree: _____Percentage of Body Surface

☐ Third Degree: _____Square Inches of Body Surface

Did burn require skin grafting? ☐ Yes ☐ No

As a result of this accident, did patient sustain a concussion? ☐ Yes ☐ No

If yes, date diagnosis made and the medical imaging procedure used _____

Did the patient suffer from any broken teeth requiring crowns or extractions? ☐ Yes ☐ No

Did the patient undergo any surgery? ☐ Yes ☐ No If so, please provide a copy of the operative report.

Do you consider the patient to be completely unable to work from the date of the accident? ☐ Yes ☐ No

If yes, how long do you believe the patient should remain out of work? _____

Activities of daily living mean: basic human functional abilities for the patient to remain independent. These include: bathing, continence, dressing, eating, toileting or transferring.

Is the patient considered to be house confined or unable to perform two or more activities of daily living? ☐ Yes ☐ No

If yes, dates: From _____ To _____

(This information will be used in accordance with state regulations and policy provisions.)

Was this patient referred to you from another physician? ☐ Yes ☐ No If yes, please provide the following:

Name of Referring Physician: _____ Telephone Number: _____

_____

Street City State Zip Code

_____ _____ _____ _____

Physician's name (please print) Degree Specialty Telephone No.

_____

Street City State Zip Code

_____ _____ _____

Signature of the Doctor Date Fax No.

May we communicate with you using email: ☐ Yes ☐ No Email Address: _____

SECTION D: EMPLOYER STATEMENT

Name of Employer: _____ Telephone number: _____

_____

Street City State Zip Code

Employee's Title: _____

What are the employee's job duties? (If possible please provide job description):

_____

Average Hours Worked Weekly: _____ Annual Salary: _____ Last Date Worked: _____

Dates this employee has been unable to work: From _____ To _____

Date the employee returned to work _____

Did the accident occur while working for wage/profit? ☐ Yes ☐ No

Has the employee been terminated? ☐ Yes ☐ No If yes, when: _____

Has employee filed a workman's compensation claim? ☐ Yes ☐ No If yes, please provide the following:

Name of workman's compensation carrier: _____ Telephone #: _____

_____

Street City State Zip Code

Print Name of person completing form: _____ Title: _____

Signature of Employer: _____ Date _____

May we communicate with you using email: ☐ Yes ☐ No Email Address: _____

State Required Fraud Warnings

New Hampshire Residents: 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.

Arizona Residents - 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.

California Residents - 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.

Colorado Residents - 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 purposes 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.

Kansas and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Kentucky Residents - A person who knowingly and with intent to defraud any insurance company or other person files a 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.

Arkansas, Louisiana and West Virginia Residents: 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 and confinement in prison.

Minnesota Residents - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD WARNING FOR WASHINGTON, MAINE, TENNESSEE AND VIRGINIA RESIDENTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

FRAUD WARNING FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY 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.

New Jersey Residents - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Oklahoma, as well as for the residents of all states not specifically listed 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.

Fraud Warning for Alaska Residents - 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.

Fraud Warning for District of Columbia Residents - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Fraud Warning for New Mexico Residents - 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.

Fraud Warning for Ohio Residents - 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.

Fraud Warning for Texas Residents - 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.

Fraud Warning for Maryland Residents - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

RESIDENTS OF NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Residents of Florida – Any person who knowing and with intent to injury, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Resident of NY – 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim or each such violation.

Date: _____ Signature: _____

Date of Birth_____/_____/_____ Relationship if other than insured:_____

Email Communication: If you choose to communicate with us by email, you should be aware that incoming email is not secure unless it is encrypted. We strongly encourage you to use encrypted email when sending sensitive and/or confidential information. By sending sensitive or confidential email messages that are not encrypted, you accept the risk of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you also should be aware that your employer and its agents have access to email communications between you and us.

Trustmark Insurance, 100 North Parkway, Suite 200, Worcester, MA 01605
☎ **Phone: 877-201-9373**
🖷 **Fax: 508-853-2757**

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Insured Statement of Claim - Communication

EMAIL COMMUNICATION

To ensure the best and fastest communication, we would like to communicate with you using email. Please complete this section if we can communicate with you by email concerning your claim, benefits, policy, premium or condition.

May we communicate with you using email: ☐ **Yes** ☐ **No** **Email Address:** _____

To ensure a smooth email experience, please be sure that your computer has the most up to date version of Adobe Reader. You should add our email address to your address book contact list and add us to your email server or spam filter approved listing. If you don't see email from us in your email inbox, be sure to check your spam or bulk email folder.

You can choose to stop email communication at any time by revoking this authorization. If you no longer wish to communicate via email we will correspond with you via US mail. If you require copies of any communication sent to you by email in paper form, please contact us. There is no cost to you to obtain copies of email communication in paper format.

THIRD PARTY COMMUNICATION

Please complete this section if you would like us to discuss, release or provide information to a family member, friend or other third party concerning your claim, benefits, policy, premium or condition.

I hereby authorize Trustmark Insurance, its subsidiaries and duly authorized representatives to release information pertaining to my claim for benefits with the person or persons listed below:

My Spouse or Partner: _____
Name

My Family Members: _____
Name and Relationship

Other Third Party: _____
Name and Relationship

My Agent: ☐ **Yes** ☐ **No**

I authorize Trustmark to leave messages on voicemail or answering devices ☐ **Yes** ☐ **No**

I agree that information about my claim that can be released may include health information which may be related to disorders of the immune system, including but not limited to HIV and AIDS, use of alcohol or drugs, mental and physical condition, history, or treatment.

I understand that any information shared may be subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information relative to my condition.

AUTHORIZATION

I may revoke or update this authorization in writing at any time or by email to vbs_disability@trustmarkinsurance.com. Trustmark Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____
Policy Owner Signature **Date**

_____ _____-_____-_____
Printed Name **Social Security Number**