Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Pregnancy Disability Claim Form

100 North Parkway, Suite 200, Worcester, MA 01605 ☎ Phone: 877-201-9373 🖷 Fax: 508-853-2757 **www.trustmarksolutions.com**

Insured's Statement:

Last Name _____ First _____ MI ____ Policy Number_____

Address _____ Apt No._____

City _____ State _____ Zip _____

Telephone No._____-_____-_____ ❑ Home ❑ Cell ❑ Work

Birth Date ____/____/____ Soc. Sec. No. _____

Occupation at claim time? _____ Annual Income _____

Employer Name _____Employer Telephone Number:_____

Employer Address_____

Claim Information

Have you delivered yet? Yes ❑ No ❑ Did you or will you have a C-section? Yes ❑ No ❑

If you have not delivered, what is your expected delivery date? ____/____/____

Are you currently experiencing or have you experienced complications related to your pregnancy? ❑ Yes ❑ No

If yes, please describe your complications and how do they interfere with your ability to do your occupation:

What was your last day worked: ___/___/___ Are you back to work yet? Yes ❑ No ❑

If yes, when did you return to work: ___/___/___

Information Needed For Withholding And Reporting Taxes – This Section Must Be Completed

Percentage of Trustmark Premium Paid By Employer: _____%

Is the Employer Paid Premium Added to Employee's Income? ❑ Yes ❑ No

Percentage of Trustmark Premium Paid By Employee: _____%

Is Employee Portion of Premium Paid with: ❑ Pre-Tax Dollars ❑ Post-Tax Dollars

Percentages must total 100%. We will assume 100% of premium is paid by employer and that the premium was not added to the employee's income. FICA taxes will be calculated accordingly.

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.

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 risks 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 communication between you and us.

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INSURED STATEMENT OF CLAIM – CONTINUED – EMPLOYMENT VERIFICATION

Please be advised that these statements may be confirmed with your Employer

Employer Name: _____

Employer Address: _____

Were you employed at the time of your impairment? Yes ❑ No ❑

Hours worked during the week _____ Check regular work schedule S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S ❑

Full-Time? Yes ❑ No ❑ If NO, How many hours did you work per week? _____

Annual income prior to disability? $_____ Base: $_____ *O/T: $* _____

How often were you paid? Weekly ❑ Biweekly ❑ Semi Monthly ❑ Monthly ❑

Hire Date _____/_____/____ Date you last worked _____/_____/_____

If terminated: Date _____/_____/_____ Resigned ❑ Dismissed ❑ Laid Off ❑

Is your present condition the result of an accident or injury on the job? Yes ❑ No ❑

If yes, date of accident _____/_____/_____ Have you filed a Workers Compensation Claim? Yes ❑ No ❑

Occupational Title(s) _____ # of hours worked in a normal week _____

Nature of employer's business _____

Supervisor's Name: _____ Years with employer _____

Years in occupation _____ If retired, date of retirement ___/___/___

Please provide a description of your occupation to include your important duties (attach separate sheet if necessary)

Duty_____

Duty_____

Duty_____

Duty_____

Please explain how your condition has interfered with the performance of your job. Please be specific.

_____

_____

_____

Employer Human Resource Contact:

Name:_____ Title_____

Telephone (_____) _____ Fax (_____) _____

PLEASE ATTACH A COPY OF YOUR MOST RECENT PAY STUB – PRIOR TO DISABILITY

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Information Pertaining To Policy Premiums

In order to prevent the loss of your policies, it is necessary to have any premiums due paid appropriately. As a service to you, we can withhold premiums from your benefits for as long as you are receiving benefit payments if you agree. Please denote below which you would prefer regarding your premium payments:

Please note that this service is not available if premiums are paid via payroll deduct on a pre-tax basis.

☐ **Yes,** Please maintain my Trustmark policy(s) in force by withholding premiums while I am receiving benefit payments.

☐ **No**, I will make the payments myself, as needed to maintain my policy(s).

Fraud Statement for Alaska and New Hampshire 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 Statement for AZ 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.

Fraud Statement for CA Residents: For your protection, California law requires the following to appear: 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 Statement for CO 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 purpose 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.

Fraud Statement for FL Residents: 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.

Fraud Statement for 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.

Fraud Statement for KY 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.

Fraud Statement for Louisiana, New Mexico, Texas, 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.

Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Fraud Statement for MN 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 STATEMENT FOR DISTRICT OF COLUMBIA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON 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 OR A DENIAL OF INSURANCE BENEFITS.

FRAUD STATEMENT 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.

Fraud Statement for New Jersey: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Fraud Statement 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 Delaware, Idaho, Indiana, and Oklahoma, As Well as for the Residents of All States Not Specifically Listed WARNING: 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 is a felony.

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DISCLOSURE AUTHORIZATION - INSURED STATEMENT OF CLAIM- Continued

Insured's name (Please Print): _____ SS# _____

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 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, credit history 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, credit reports, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Administration to release information or records about me to Trustmark Insurance Company or its authorized representatives. Such release of Social Security information will be used to adjudicate my claim in accordance with my policy benefits, or to continue my eligibility for benefits. I further request that the Social Security Administration release detailed earnings for up to the last ten years and/or a summary record of total earnings and/or information from master benefit records regarding award, denial or continuing Social Security benefits.

I understand that I may revoke this authorization at any time. Any such revocation is to be in writing, signed and dated by me, and must be forwarded directly to 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 me, A photocopy of this Authorization is as valid as the original and I may request a copy. I understand that if I choose I may request a copy of any credit report Trustmark receives in connection with this authorization. This Authorization will be in force for the term of coverage of the policy or up to 12 months from the date shown below, whichever time period is less.

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.

Residents of CA – the first sentence of the AUTHORIZATION is changed as follows: 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 persons having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employees and agents, or any 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.

Residents of AZ - You or your authorized representative are entitled to receive a copy of this Disclosure Authorization.

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 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 for each such violation.

RESIDENTS OF ME: 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 OR A DENIAL OF INSURANCE BENEFITS.

Date: ____/____/____ Insured's Signature: _____

Date of Birth: ____/____/____ Relationship, if other than insured: _____

If I receive disability income payments greater than those, which should have been paid, I understand that I will be requested to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not returned.

I hereby declare that all statements given herein in the preceding pages are true and complete to the best of my knowledge and belief.

Date: ____/____/____ Signed: _____ Print Name: _____

Relationship, if other than insured: _____

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Claimant's Name: _____ Date of Birth _____/_____/____ Policy #: _____

PHYSICIANS STATEMENT ***(To Be Completed By Attending Physician)***

Date of patient's last menstruation: _____/_____/_____ Date of first treatment for this pregnancy: _____/_____/_____

Please list any complications of pregnancy: _____

_____

Has patient been hospital confined: Yes ❑ No ❑ If no, what is the estimated date of confinement: ____/____/____

If yes, what is the date of delivery: ____/____/____ and discharge date: ____/____/____

Did patient undergo, or will patient undergo a C-section? Yes ❑ No ❑

Date you advised patient to stop working: ____/____/____

Physician's name (please print)_____ Specialty_____

Phone_____-_____-_____ Fax_____-_____-_____ Address_____

Signature_____ Date ____/____/____

Please be sure all portions of claim form are completed as directed