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

Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

# INSURED STATEMENT OF CLAIM

Last Name _____ First _____ MI ____ Policy Number_____

Address _____ Apt No._____

City _____ State _____ Zip _____

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

E-Mail Address: _____

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

Gender: ❑ M ❑ F Height_____ Weight_____ Spouse's Name _____

Is your disability due to an ❑ Accident/Injury, or a ❑ Sickness? When did your disability begin? ____/____/____

Please describe where & how your disability occurred & what illness/injury resulted:

_____

_____

_____

Have you had a similar illness/injury? ❑ Yes ❑ No If yes, date(s) _____

Date of first treatment by a physician for this condition ____/____/____

Name & Address of physician or hospital who first treated you for this condition:

Physician Name_____Address_____

Physician Name_____Address_____

Hospital Name_____Address_____

Hospital Name_____Address_____

If hospitalized, provide dates and name of hospital:

Dates Confined ___/___/___ to ___/___/___ Hospital _____

I was unable to work from: _____/_____/_____ to _____/_____/_____

I returned to work in a limited capacity from ____/____/____ to _____/_____/_____

List any Physicians, Surgeons & Health Care Providers who attended to you and/or Pharmacies you have utilized during the past 3 years. Attach additional sheets if needed.

Name_____Address_____Reason_____

Name_____Address_____Reason_____

List any periods of hospitalization you have had during the past 3 years:

Hospital Name: _____ Dates of hospitalization:_____

Hospital Name: _____ Dates of hospitalization:_____



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

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# INSURED STATEMENT OF CLAIM - CONTINUED

Please indicate any benefits that you are eligible to receive:

| Source | Amount | Date Applied | Payments Began | Payments End |
|---|---|---|---|---|
| State Disability | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Soc. Sec. | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Workers' Comp | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Unemployment | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Retmnt/Pension | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Other _____ | $_____ | ____/____/____ | ____/____/____ | ____/____/____ |

If you have other disability insurance coverage please complete the information below:

Company Name_____Policy #_____

Benefit Amount/month $_____Effective date of Coverage ___/___/_____

Company Name_____Policy #_____

Benefit Amount/month $_____Effective date of Coverage ___/___/_____

**Information Needed For Withholding And Reporting Taxes – <u>This Section Must Be Completed</u>**

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.*

**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).

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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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**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.

**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 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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## 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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# 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**

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## EMPLOYERS STATEMENT *(To Be Completed By Employer)*

Employee's name _____ Soc. Sec. No. _____ Hire Date _____/_____/____

Birth Date _____/_____/_____ Job Title _____

Date employee last worked _____/_____/_____ If terminated: Date _____/_____/_____

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

If yes, date of accident _____/_____/_____ Has a Workers Compensation Claim Been Made Yes ❑ No ❑

Was employee working modified duties prior to last day worked? Yes ❑ No ❑

If yes, please describe: _____

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

Date employee returned to Regular duties: F/T ____/____/____ P/T ____/____/____

If available Light duties: F/T ____/____/____ P/T _____/_____/_____

Employee's annual Base salary preceding disability Base: $_____ O/T: $ _____

Is salary based on 12 months? Yes ❑ No ❑ _____ mos.

**COMPLETE ONLY IF DATES ARE INDICATED***

Was employee absent from work for any reason, other than vacation or pregnancy, during the period of:

* _____ thru _____ Yes ❑ No ❑

**(Please note the above dates will not be the same as the current disability)**

If Yes: Date:____/____/____ Cause: _____

Date: ____/____/____ Cause: _____

Employer _____ Telephone _____ Fax _____

Address_____

Signature _____ Title_____

Date ____/____/____

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

## PLEASE ATTACH A COPY OF THE JOB DESCRIPTION

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

Name of patient _____Date of birth _____/_____/_____SSN_____-_____-_____

Date patient first reported symptoms or accident happened _____/_____/_____

Date patient advised to stop working because of impairment _____/_____/_____

Date of first treatment _____/_____/_____ Dates of subsequent treatments_____, _____,_____,_____,_____

***CHECK YOUR RESPONSES***: Is this condition due to: an Accident ❑ a Sickness ❑ ?

Is the accident or sickness related to the patient's employment? Yes ❑ No ❑

Is condition due to Pregnancy Yes ❑ No ❑ Est. Date of Delivery: _____/_____/_____ Actual Delivery Date ____/____/____

Delivery Type: ❑ Vaginal ❑ C-Section – If C-Section: ❑ Elective ❑ Non-Elective

Did another physician refer this patient to you? Yes ❑ No ❑

If yes, please list name, address, and specialty_____

**PATIENTS CONDITION**

Primary diagnosis_____Subjective symptoms_____

Clinical findings (including the results of X-rays, EKG's, laboratory data, pertinent physical examination notes, etc.)

_____

_____

Has patient been hospital confined? ❑ Yes ❑ No From _____/_____/_____ To _____/_____/_____

If yes, Hospital name_____

Do you consider the patient to be completely unable to work in his/her occupation? Yes ❑ No ❑

If yes, please provide dates From _____/_____/_____ To _____/_____/_____

If still completely unable to work, when do you expect patient will be able to return to his/her work duties?

❑ 1 – 3 mo. ❑ 3 – 6 mo. ❑ 6 – 12 mo. ❑ More than 12 mos.

If patient is able to do some work, for what period will patient be restricted from his normal duties?

From ____/____/____ To ____/____/____

What are patient's current limitations_____

Is patient competent to endorse checks and direct the use of proceeds thereof? Yes ❑ No ❑

Physician's name (please print)_____Degree _____Specialty_____

Phone_____-_____-_____ Fax_____-_____-_____ Address_____

Signature_____ Date ____/____/____

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



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