

**INSURED STATEMENT OF CLAIM**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ Apt No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Telephone No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Telephone Number: \_\_\_\_\_

Employer Address \_\_\_\_\_

Were you employed at the time of your impairment? Yes  No  Full-Time? Yes  No

Annual income prior to disability? \$ \_\_\_\_\_

How often were you paid? Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Semi Monthly \_\_\_\_\_ Monthly \_\_\_\_\_

Were you injured at work? Yes  No  Have you filed a Workers Compensation Claim? Yes  No

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 \_\_\_\_\_

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: \_\_\_\_\_

**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 \_\_\_/\_\_\_/\_\_\_

**Occupation**

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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Percentage of Premium Paid By Employer: \_\_\_\_\_% Is Employee Taxed on this amount?  Yes  No

Percentage of Premium Paid By Employee: \_\_\_\_\_%  Pre-Tax Dollars  Post-Tax Dollars

Percentages must total 100%. If left blank, we will assume 100% of premium is paid by employer and that employee is not taxed on this amount. 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).

**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.

**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: \_\_\_\_\_

**INSURED STATEMENT OF CLAIM- Continued**  
**OPTIONAL**

**AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTIES**

You are not required to complete this authorization. If you would like us to discuss, release or provide information about your claim, benefits, policy, billing, or condition to a third party, family member or friend, the completion of this form will provide a record of whom we can discuss the above information with, in the event you would not be the main contact. Please complete this form in full and return it with the other documents of your statement of claim if you want us to discuss your claim, policy, billing or condition with someone other than yourself.

**DISCLOSURE AUTHORIZATION TO THIRD PARTIES**

I hereby authorize Trustmark Insurance, its subsidiaries and duly authorized representatives to release information pertaining to my claim for benefits with the family member(s), friend(s) or other third parties listed below who are assisting me in the administration of my claim(s):

My Spouse or Partner: \_\_\_\_\_  
NAME

My Family Member: \_\_\_\_\_  
NAME / RELATIONSHIP

Other Third Party: \_\_\_\_\_  
NAME / RELATIONSHIP

I authorize Trustmark Insurance to leave messages on voicemail or answering devices. Yes \_\_\_\_\_ No \_\_\_\_\_

I authorize Trustmark Insurance to release information concerning my claim to my Agent. Yes \_\_\_\_\_ No \_\_\_\_\_

I agree that Information about my claim that could 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 conditions, 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.

I may revoke this authorization in writing at any time to the above address. Trustmark Insurance will be allowed to rely on the information provided by third parties in the adjudication of my claim until receipt of my revocation notice. This authorization is valid for the shorter of two 2 years or the duration of my claim if shorter. 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

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason not working:  Sickness  Injury  Retired  Resigned  Granted LOA  Dismissed  Vacation  Laid Off  
 Other \_\_\_\_\_

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

Were there any layoffs planned at employee's location? Yes  No

Job Classification:  Heavy Labor  Moderate Labor  Light Labor  Sedentary/Clerical Labor

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

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.

If premiums are paid through payroll deduction, please provide date of last payroll deduction for premiums: \_\_\_\_/\_\_\_\_/\_\_\_\_

In the past 36 months has employee received workers compensation benefits? Yes  No

If Yes, what dates? \_\_\_\_/\_\_\_\_/\_\_\_\_ , \_\_\_\_/\_\_\_\_/\_\_\_\_ , \_\_\_\_/\_\_\_\_/\_\_\_\_

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 \_\_\_\_\_

**PLEASE ATTACH A COPY OF THE JOB DESCRIPTION**

Please attach incident report if a Workers Compensation Claim was filed

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

**Trustmark**  
INSURANCE COMPANY

**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

Have you completed claim forms regarding this patient for other insurance carriers? Yes  No

If Yes, Name of Insurance Company \_\_\_\_\_

Physician's name (please print) \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_