Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

STATEMENT OF CLAIM – CAREGIVER BENEFIT

For Claims Customer Service: ☎ Phone: **877-201-9373 x45708**
For Claims Submission: 🖷 Fax: **508-853-2757** Email: ***VBS_Disability@Trustmarkins.com***

For purposes of this form, the below definitions pertain:

Home Health Care*:* Personal care including assistance with bathing, dressing and personal hygiene, feeding; dressing changes, monitoring of vital signs, body positioning and basic exercise; medication administration, supervision for safety.

Homemaking*:* Assistance with light housekeeping, shopping and meal preparation, laundry, medication management, bill paying.

Transportation: Assisting individual in order to access needed services outside of home for medical professional services or rehabilitative care.

Person Needing Care:

Last Name _____ First _____ MI ____

Address _____ Apt No._____

City _____ State _____ Zip _____

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

Insured Certification/Person Providing Care:

Last Name _____ First _____ MI ____

Address (If Different from above)

Street _____ Apt No._____

City _____ State _____ Zip _____

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

E-Mail Address: _____

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

The above patient requires Caregiving due to: (check all that apply)

❑ Cancer **❑ Coronary Disease** **❑ Cerebral Vascular Disease**

I hereby certify that I have provided Caregiving services to the above listed individual three or more times per week, individually or in combination, ***for two or more weeks***. I further certify that the person receiving Caregiving services is a spouse, child, parent or sibling. I understand that an Eligible Family Member as defined in the Policy may be verified by Trustmark Insurance. I further verify that I am not receiving compensation for providing such service.

Signature_____ Date: _____/_____/_____

Print Name _____ **Policy Number**: _____

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HIPAA AUTHORIZATION FORM
FOR THE RELEASE OF INFORMATION

Patient's Full Name

Name of Patient's Guardian/Personal Representative **(if applicable)**

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____
   Name of Medical Provider

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Trustmark Insurance Company

   100 North Parkway, Worcester MA 01605
   Address

   508-853-2757
   Fax Number

3. The specific information that should be disclosed is:

   All medical records and/or documentation related to my physical or mental health.

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION _____

4. I understand that this authorization is voluntary and I may refuse to sign it.
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and may then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying Trustmark Insurance Company in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. The specific purpose/use of the disclosure of this information is for insurance determinations and/or other insurance purposes by Trustmark Insurance Company.
8. I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for healthcare benefits.
9. This authorization is valid for one year from the date this authorization is signed OR until I revoke it, whichever is earlier.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____ _____
Signature of Individual **Date of Individual's Signature**
(The person about whom the information relates)

OR, if applicable –

_____ _____ _____
Signature of Guardian or Personal Representative of Patient | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature

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.

Trustmark Insurance, P.O, Box 60676, Worcester, MA 01606
☎ **Phone: 877-201-9373 x45708** 🖷 **Fax: 508-853-2757**

Insured Statement of Claim - Communication

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CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS TEXT MESSAGING)

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

May we communicate with you electronically?

☐ No

☐ Yes, by Text Messages Please provide cell phone #: (_____) -_____- _____

☐ Yes, by Email Please provide email address:_____@ _____

If you chose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic 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 should also be aware that your employer and its agents, have access to electronic communication between you and us.

I understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Trustmark and I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked in writing.

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 electronic communication at any time by revoking this authorization. If you no longer wish to communicate via electronic means we will correspond with you via US mail. If you require copies of any communication sent to you by email/text in paper form, please contact us. There is no cost to you to obtain copies of electronic 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's Name: _____

My Family Member(s): _____ _____
Name and Relationship *Name and Relationship*

Other Third Party: _____ My Agent: ☐ Yes ☐ No
Name and Relationship

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@trustmarkins.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***

Trustmark Insurance ♦ P.O. Box 60676 ♦ Worcester, MA 01606
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Physician Certification

Medical Certification for:_____

(**Name of individual in need of Caregiver services**)

Physicians Name:_____

Business Address:_____

Medical/Surgical Specialty:_____

Telephone:_____ Fax:_____

The above patient requires Caregiving due to: (check all that apply)

❑ **Cancer**

❑ **Coronary Disease**

❑ **Cerebral Vascular Disease**

Date the clinical condition(s) diagnosed: ___/____/_____

Caregiving required for the following (check all that apply):

_____ **Home Health Care**: Personal care including assistance with bathing, dressing and personal hygiene, feeding; dressing changes, monitoring of vital signs, body positioning and basic exercise; medication administration, supervision for safety.

_____ **Homemaking**: Assistance with light housekeeping, shopping and meal preparation, laundry, medication management, bill paying.

_____ **Transportation**: Assisting individual in order to access needed services outside of home for medical professional services or rehabilitative care.

If Yes, as of what date? _____/_____/_____

Have these caregiving needs, individually or in combination, occurred at a minimum frequency of 3 times a week and been continuous for at least two weeks? ❑Y ❑N

Physician Signature_____ Date: _____/_____/_____