Trustmark Voluntary Benefit Solutions
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Critical Life Events – Specified Illness Claim Form

For Claims Customer Service: Phone: 877-201-9373 x45708

For Claim Submission: Fax: **508-853-2757** Email: **VBS_Disability@trustmarkins.com**

This form must be completed by the Attending Physician and the Policyholder and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible. Please keep a copy of this form and any attachments for your records. **The policyholder is responsible for completion of all portions of this form without expense to Trustmark Insurance Company.**

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

SECTION A

Policyholder Information **Policy Number(s)**	**Patient Information Check One:** ☐**Spouse** ☐**Child** ☐**Self**
E-mail Address	
Name (First, Middle, Last) ☐Male ☐Female	Name (First, Middle, Last) ☐Male ☐Female
Address (Street) ☐Check here if NEW address Apt #	Address (Street) ☐Check here if NEW address Apt #
City State ZIP Code	City State ZIP Code
Social Security Number **Date of Birth** / /	**Social Security Number** **Date of Birth** / /
Phone Number ( ) ❑ Home ❑ Cell ❑ Work	Phone Number ( ) ❑ Home ❑ Cell ❑ Work
Employer's Name	

SECTION B

Check illness being claimed	Specified Illness
	Blindness Permanent loss of visual acuity based on either: 1. Best corrected visual acuity of 20/400 or worse, or 2. Visual field of 20 degrees or worse in the better eye; Without expectation for improvement.
	Complications of Diabetes Diabetes causes an amputation of a lower limb, which includes all areas at or above the forefoot, as a result of the diabetic condition.
	Loss of Hearing Clinically proven irreversible loss of hearing in both ears, with anticipated best corrected auditory threshold of more than 90 decibels, through surgery, hearing aid, device, or implant.
	Major Organ Failure Failure of one of the following major organs: • Liver • Lung • Pancreas • Heart

SECTION B Continued

Check illness being claimed	Specified Illness
	Occupational Human Immunodeficiency Virus (HIV) The contracting of HIV caused by a needle stick or sharp injury or mucous membrane exposure to blood or bloodstained bodily fluid.
	Paralysis Clinical Diagnosis of a complete and irreversible condition marked by loss of muscle function in two or more limbs (paraplegia, quadriplegia, hemiplegia) as the direct result of an illness or disease, which is not expected by a Physician to reverse or resolve.
	Renal Failure Chronic renal failure, which is the irreversible failure of the function of both kidneys such that regular dialysis is required to sustain life.
	Central Nervous Condition Lupus, Sarcoid, or central nervous infection of the brain which leads to brain damage resulting in neurological impairment which is objectively measured, is confirmed by neuroimaging studies, and a medical professional has determined that neurological impairment resulted from the condition currently being diagnosed and was not previously present, and has persisted for 30 days or longer.
	Complications of Diabetes Life threatening complications due to diabetes characterized by: 1. Extreme hyperglycemia and dehydration, and 2. A Physician's determination that immediate hospitalization is necessary.
	Stem Cell/ Bone Marrow Transplant When there is infusion or injection of healthy stem cells into the body to replace damaged or diseased stem cells.

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 ____

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 three (3) years:			
Hospital Name:		Dates of hospitalization	
Hospital Name:		Dates of hospitalization	

The statements made by me on this claim are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices on the instruction page.

Signature of Claimant **X**_____________________________________ Please Print Name ______________________________________

Date Signed: ____/____/____ Social Security Number ______________

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

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INSURED STATEMENT OF CLAIM - CONTINUED

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).

State Required Fraud Warnings

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.

Signed 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

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

Name of patient____Date of birth ___/___/___ SSN____/_____/_____

Date patient first reported symptoms or accident happened_______/_____/______

Date of first treatment: ___/___/___ Dates of subsequent treatments: ______, ______, _____, _____, _____

CHECK YOUR RESPONSES: Is this condition due to: an Accident ❑ a Sickness ❑ ?
Did another physician refer this patient to you? Yes ❑ No ❑

If yes, please list name, address, and specialty: ____

PATIENTS CONDITION

Primary diagnosis and date of diagnosis please check off below:

Physician's Statement		
Check illness being claimed	**Specified Illness**	**Date of Diagnosis**
	Blindness - Permanent loss of visual acuity based on either 1) best corrected visual acuity of 20/400 or worse, or 2) visual field of 20 degrees or worse in the better eye; without expectation for improvement. **Date of Diagnosis** - the date a licensed ophthalmologist physically examines and certifies that the definition of Blindness is met.	
	Complications of Diabetes - diabetes causes an amputation of a lower limb, which includes all areas at or above the forefoot, as a result of the diabetic condition. **Date of Diagnosis** - the date of surgery when amputation occurs	
	Loss of Hearing - Clinically proven irreversible loss of hearing in both ears, with anticipated best corrected auditory threshold of more than 90 decibels, through surgery, hearing aid, device, or implant. **Date of Diagnosis** - the date on which a licensed audiologist physically examines and certifies that the definition of Loss of Hearing is met.	
	Major Organ Failure - Failure of one of the following major organs: liver, lung, pancreas, or heart. **Date of Diagnosis** - the date placed on a medically accredited transplant list for a transplant.	
	Occupational Human Immunodeficiency Virus (HIV) - The contracting of HIV caused by a needle stick or sharp injury or mucous membrane exposure to blood or bloodstained bodily fluid. **Date of Diagnosis** - the date on which the follow-up blood test results are received which confirm the diagnosis of HIV.	
	Paralysis - Clinical Diagnosis of a complete and irreversible condition marked by loss of muscle function in two or more limbs (paraplegia, quadriplegia, hemiplegia) as the direct result of an illness or disease, which is not expected by a Physician to reverse or resolve.	
	Renal Failure - Chronic renal failure, which is the irreversible failure of the function of both kidneys such that regular dialysis is required to sustain life. **Date of Diagnosis** - the date the physician determines the presence of chronic irreversible failure or both kidneys.	

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Physician's Statement (Continued)

Check illness being claimed	Specified Illness	Date of Diagnosis
	Central Nervous Condition - Lupus, Sarcoid, or central nervous infection of the brain which leads to brain damage resulting in neurological impairment which is objectively measured, is confirmed by neuroimaging studies, and a medical professional has determined that neurological impairment resulted from the condition currently being diagnosed and was not previously present, and has persisted for 30 days or longer.	
	Complications of Diabetes - Life threatening complications due to diabetes characterized by 1) extreme hyperglycemia and dehydration, and 2) a Physicians determination that immediate hospitalization is necessary. **Date of Diagnosis** - the date of hospitalization.	
	Stem Cell/ Bone Marrow Transplant - When there is infusion or injection of healthy stem cells into the body to replace damaged or diseased stem cells. **Date of Diagnosis** - the date the stem cell or bone marrow infusion or injection is received.	

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

____

____

____

Has patient been hospital confined? ❑ Yes ❑ No If Yes, From ____/____/____ To ____/____/____

If yes, Hospital name: ____

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

Physician's Name (please print): ______________________________________

Physician's Signature: ______________________________________ Date: _____/_____/_____

______________________________ ______________________________

Degree *Specialty*

Phone: ______-______-________ Fax: ______-______-________

Address: ____

May we communicate with you using email? ❑ Yes ❑ No

If yes, Email Address: ____