Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Healthy Living Rider Claim

For Claims Customer Service: ☎ **Phone:** 877-201-9373 x45704
For Claims Submission: **Fax:** (508) 471-3207 **Email:** CriticalLifeEventsClaims@Trustmarkins.com
Mail: PO Box 60676, Worcester, MA 01606

Instructions for Claim Submission

Please be sure to attach copies of *Outpatient Bills / Invoices* or *Explanation of Benefits* to document the testing/services you had completed.

Please complete a SEPARATE form for each individual and/or each calendar year that you are claiming benefits.

- **Section A, B & D -** Complete these sections and return to us for review of benefits. All questions must be answered in full. ***Incomplete or illegible answers may result in delay of benefits***. Please keep a copy of all parts of this form and any attachments for your records.
- **Section C-** Complete this section only if as the result of a covered test or service you required and received a follow-up diagnostic test.
- **Section E –** Complete only if services provided through an employer sponsored wellness clinic for which you have no other documentation.

- **Electronic Communication and State Required Fraud Language:** Attached for your information
- **Insured Statement of Claim Communication:** Please complete the Third Party Authorization if you would like to authorize Trustmark to release information on your claim(s) to a third party such as a spouse, friend or agent.

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Section A – Policyholder Information *(To Be completed by the Policy Owner)*

Policy #: ______________ SSN#______/____/______

Name: _______________________________________ DOB: ____/____/____ Phone #__________________ ❑Home ❑Cell ❑Work

Address: ____
Street City State Zip Code

Section B – Patient Information *(To Be completed by the Policy Owner)*

Please complete below and attach itemized copies of any related bill supporting the testing you or the patient had completed.

Name of patient: _________________________________ DOB: _____/____/____ SSN: ______-______-________

Relationship to Insured: ___________________________________ (e.g. spouse, son, daughter)

This is not a guarantee of payment. Benefits will be determined based on your policy provisions and the provisions of your Healthy Living Rider.

Please advise which routine service you had completed by providing the date it was completed in the section below.

Routine Service	Date Completed	Routine Service	Date Completed
Mammography	/ /	Flexible Sigmoidoscopy	/ /
Pap Smear for Women Over Age 18	/ /	Hemoccult Stool Analysis	/ /
Human Papillomavirus Vaccination (HPV)	/ /	EKG/ECG	/ /
Prostate Specific Antigen (PSA)	/ /	Whole Body Skin Cancer Screening	/ /
Colonoscopy	/ /	CA125 Blood Test	/ /
CT Colonoscopy	/ /	Doppler Screening for Cartoids	/ /

Some select policies include coverage for two additional services. If your policy includes these two additional services, please complete below if you are claiming either of the following services.

Routine SERVICE	Date Completed	Routine SERVICE	Date Completed
Biometric Screening	/ /	Genetic Testing (BRCA1 or BRCA2)	/ /

Section C: Only complete this section if, as a result of one of the above covered routine services (excluding biometric screening), you required and received a follow-up diagnostic test. Please include the date of the initial routine test, the date of the follow-up diagnostic test and the name of the diagnostic test.

_____/______/______ _____/______/______ ___________________________________
Date of routine test *Date of follow up diagnostic test* *Name of follow up diagnostic test completed*

Section D: Please sign, print your name and date below to certify to the accuracy of information provided.

______________________________ ______________________________ _______/______/_______
Policy Owner Signature Print Name Date

Section E: Only have this section completed if the claimed testing was completed as part of a wellness clinic sponsored by your employer and you have no documentation of the date and type of test provided. To be completed by the Medical Professional who completed the testing.

______________________________ ______________________________ _______/______/_______
Signature of Medical Professional Print Name Date

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Electronic Communication: If you choose 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 email communication between you and us.

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 Arkansas, 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 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 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 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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Insured Statement of Claim – Communication

Third Party Communication Authorization

Please complete this authorization if you would like us to discuss, to release, or to provide information to a family member, friend, or other third party such as your agent or employer.

My Spouse or Partner: (Name) ____

☐ All Information (All policy and claim information)

☐ All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

My Family Member: (Name and Relationship)

____

☐ All Information (All policy and claim information)

☐ All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

Other Third Party: **My Agent:** Yes ☐ **My Employer:** Yes ☐

Or Name a Specific Third Party (Name and Relationship) ____

☐ All Information (All policy and claim information)

☐ All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

I agree that if I authorize release of all claim information this 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 re-disclosure 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 **CriticalLifeEventsClaims@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 (Or Policy Owner's Personal Representative's Signature ***Date***

____ ______ - ______ - ______
Printed Name ***Social Security Number***

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