Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Critical Illness / Cancer 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.

INSTRUCTIONS:

Section A & B: These sections must be completed by you, the policyholder.

Attending Physician Statement: This section must be completed by the physician primarily responsible for the patient's care. Please make sure all dates of treatment are indicated in this section and that the physician signs and dates the form.

Please note that a checked condition does not guarantee benefits. Benefits are determined by the terms and conditions of your policy/certificate.

State Required Fraud Language: For your information.

Disclosure Authorization: Sign and date this form. Provide a copy of the signed and dated form to the attending physician.

Insured Statement of Claim - Communication: Complete only if you would like us to communicate with you by email **OR** if you would like us to discuss, release or provide information to others you designate regarding your claim."

Please enclose any additional information that you feel will assist us in evaluating this claim

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** / /	
Home Phone Number ( )	Work Phone Number ext. ( )		Home Phone Number ( )	Work Phone Number ext. ( )	
Employer's Name					

SECTION B

What type of illness are you claiming?			When were you first treated for this illness? (Date mm/dd/yyyy) / /		
Primary Doctor Name			**Treating Doctor** Name		
Address (Street)			Address (Street)		
City	State	ZIP Code	City	State	ZIP Code
Phone Number ( )	Fax Number ( )		Phone Number ( )	Fax Number ( )	

Note: Please include a list of all physicians/facilities from which you have received treatment including your primary care physician. You may attach a separate piece of paper for this information.

HOSPITAL INFORMATION (If ever hospitalized or seen at the hospital for this condition)					
Hospital Name			Hospital Name		
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
Hospital Phone Number			Hospital Phone Number		
Date Seen/Admitted	/	/	Date Seen/Admitted	/	/
Date Discharged	/	/	Date Discharged	/	/

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.**

ATTENDING PHYSICIAN'S STATEMENT - CRITICAL ILLNESS

1. Patient's Name (first, middle initial, last name)

2. Patient's Birth Date _____/_____/_____

3. Patient's SSN ______ - ______ - ______

4. Patient's Gender ☐ Male ☐ Female

5. Date of Diagnosis _____/_____/_____

6. Date first consulted you for this condition ___/____/____

7. Has patient previously had same or similar condition: ☐ Yes ☐ No If yes, first treatment date(s) ____/____/____

8. Name of referring or other treating physicians

9. For services related to hospitalization provide hospitalization dates Admit: ____/____/____ Disch: ____/____/____

10. Name and address of facility where services rendered (if other than home or office):

11. Diagnosis or nature of illness:

12. Please check the condition that applies to this patient and provide the test results, operative reports, pathology reports, and/or your detailed medical statements as required for the condition indicated below: (Check all that apply)

Condition			Required Supporting Documentation
☐ Amyotrophic Lateral Sclerosis (ALS)(Lou Gehrig's Disease)			Medical reports, Neurological reports
☐ Benign Tumor			Medical Documentation
☐ Other Condition Description:			Medical Documentation to support diagnosis
Cancer Tissue/Organ of Origin:	Stage:	Grade:	Pathology Report
☐ Carcinoma in situ			Pathology report and/or Clinical Diagnosis
☐ Leukemia			Clinical Diagnosis
☐ Coronary Artery Obstruction - % occluded:			Coronary angiography report
☐ Coronary Artery Bypass Surgery			Open heart surgical report
☐ Coronary Artery Disease			Medical Documentation
☐ Heart Attack			Any of the following: Electrocardiogram (EKG), Cardiac enzymes, Thallium scans, MUGA scans, Stress Echocardiogram
☐ Major Organ Transplant			Surgical Reports
☐ Stroke			Documented neurological deficits and/or neuroimaging studies
☐ Transient Ischemic Attack (TIA or RIND)			Clinical Exam Diagnostic Evaluation

13. Your Patient's Account Number

Attending Physician - Print or Type Your Name | Degree | Medical Specialty

Street Address | Telephone Number ( )

City | State | ZIP Code | Fax ( )

Signature of Physician | Date _____/_____/_____

Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship?

May we communicate with you using email: ☐ Yes ☐ No Email Address:______________________________

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.

DISCLOSURE AUTHORIZATION

Insured's name (Please print):____________________________

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 other 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. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the 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 the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. 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.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

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 Florida – Any person who knowing and with intent to injury, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Resident 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 or each such violation.

Date: _______________________ Signature: ____

Date of Birth______/______/______ Relationship if other than insured:________________________________

Trustmark Insurance, P.O, Box 60676, Worcester, MA 01606

☎ **Phone: 877-201-9373 x45708** 🖷 **Fax: 508-853-2757**

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Insured Statement of Claim - Communication

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***