INSURED STATEMENT OF CLAIM – ADDITIONAL SICKNESS - STANDARD ACTIVITIES BENEFIT

POLICYOWNER INFORMATION

Last Name ______________________________ First ____________________ MI ____ Policy Number__________________

Address ____ Apt No.________

City ____ State ________ Zip ________________

Telephone No.______-________-________ ❑ Home ❑ Cell ❑ Work E-Mail Address: ____________________________

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

CLAIMANT INFORMATION:

Claimant's Last Name ________________________________ First________________________ MI_____

Address: ____

(If different from above)

Are Claimants restrictions due to an ❑ Accident/Injury, or a ❑ Sickness?

What is your diagnosis or cause of your limitations? ____

Have you ever had a similar illness? ❑ Yes ❑ No If yes, date(s) ____

Based on the below definitions please check **ALL** Standard Activities the claimant is not able to perform as a result of the above diagnosis:

❑ **Bathing** – the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment.

❑ **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs.

❑ **Toileting** – the ability to get to and from the toilet, get on or off the toilet, and perform associated personal hygiene with or without the assistance of equipment.

❑ **Transferring** – the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment; mobility, the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.

❑ **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment.

❑.**Continence** – the ability to voluntarily maintain control of bowel and/or bladder function or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

When did at least 2 of the Daily Activity Limitations begin? ____/____/____ Are they still present? ❑ Yes ❑ No

Date of first treatment by a physician for this condition ____/____/____

Please provide the Name & Address of physicians or hospital who are or have treated this condition:

Physician Name_____________________________________Address____

Hospital Name______________________________________Address____

If hospitalized, provide dates and name of hospital:

Dates Confined ___/___/___ to ___/___/___ Hospital ____

Dates Confined ___/___/___ to ___/___/___ Hospital ____

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.

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**
(The person about whom the information relates)

______________________________ **Date of Individual's Signature**

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

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

Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

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***

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

Name of patient _______________________________________Date of birth _____/_____/_____ SSN______-______-_______

Date patient first reported symptoms _____/_____/_____

Date of first treatment _____/_____/_____ Dates of subsequent treatments________, _______, ________, _______, _______

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: ____

PATIENTS CONDITION

Primary Diagnosis_______________________________________ Subjective symptoms_____________________________________

Based on your findings, which of the below Standard Activities is your patient **not able to complete**? :(check all that apply)

❑ **Bathing** – the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment.
❑ **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs.
❑. **Toileting** – the ability to get to and from the toilet, get on or off the toilet, and perform associated personal hygiene with or without the assistance of equipment.
❑ **Transferring** – the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment; mobility, the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.
❑ **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment.
❑.**Continence** – the ability to voluntarily maintain control of bowel and/or bladder function or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

When did these Standard Activity Limitations begin? ____/____/____

How long are these Limitations expected to last? ❑ 1 mo. ❑ 2 mo. ❑ 3 mo. ❑ More than 3 mos.

Do you believe the patient requires Professional care? Yes ❑ No ❑

If No, do you believe the patient's Spouse is able to provide care for your patient with the above checked activities of daily living?
Yes ❑ No ❑

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

PLEASE PROVIDE ANY SUPPORTING MEDICAL RECORDS RELATED TO THE ABOVE.

Physician's name (please print) __________________________________Degree ________Specialty______________________

Phone_____-_____-_______ Fax_____-______-_____ Address____

Signature____ Date ____/____/____