Voluntary Benefit Solutions
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

Critical Life Events – Waiver of Premium – DI Claim Form

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

This form must be completed by the Insured, Employer and the Attending Physician 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.

PART A – Insured Statement (To Be Completed By Insured)

Name of Insured_____Date of Birth____/____/___ Policy Number_____

Social Security #_____

Insured's Address _____ Phone #_____
(Street) (City) (State)

Name and Address of Employer_____Date Employed ____/____/____

Occupation:_____ Principal Duties: _____

Doctors Consulted:

_____
(Name) (Address) (Dates)

_____
(Name) (Address) (Dates)

_____
(Name) (Address) (Dates)

Name of Hospital_____ Date Admitted ____/____/___ Date Discharged ____/____/____

Describe nature of illness or injury _____

1. If **Illness**, on what date did you first notice the illness? _____/_____/_____
2. If **Accident/Injury**, date occurred? ____/____/____ Where you at work? ❑ Yes ❑ No

How did accident/injury happen? _____

_____

_____

3. Date you stopped working: _____/____/____ Hour: _____ ❑AM ❑PM
4. Dates you were continuously confined to your home: From: ____/____/____ To: ____/____/____
5. Date you resumed working: _____/____/____ Hour: _____ ❑AM ❑PM
6. If unable to resume work at present, about what date should you be well enough to resume work? ____/____/____
7. Are you making a claim with any other company? ❑ Yes ❑ No

   If yes: Company Name: _____ Amount of Policy: _____

   Company Name: _____ Amount of Policy: _____

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PART A – Insured Statement (To Be Completed By Insured) (Continued)

Please provide the following information concerning your education, prior occupations, hobbies, special skills, and interest in future employment.

1. **Education**
   a. What is the level of your education? _____
   b. How many years of grade school, high school, college, etc.? _____
   c. Describe courses taken (commercial, vocational, academic, etc.) Any trade schools, military training schools, or other special training? If so, please describe:

2. **Prior Occupations:**
   a. List and give details of all previous occupations. Specify ***all duties of each occupation*** and show beginning and end dates of employment.

3. **Special Skills and Abilities:**
   a. Identify equipment, tools, and machinery that you have used or operated in the past:

4. **Hobbies:**
   a. Do you have any hobbies and/or other special interests (woodworking, mechanical repairs, painting, etc.)? If so, describe in detail:

5. **Occupational Interests:**
   a. Would some other employment interest you based on your past experience, hobbies, special training, etc.? If so, give details:

6. **Resuming Work:**
   a. Have you participated in any type of work since your disability began? If so, give details including the type of work, the duties performed and when and where your work activity took place, including employer(s) name and address.

7. **Vocational Rehabilitation:**
   a. Are you participating in a rehabilitation program sponsored by your employer, another insurer or any other program? □ Yes □ No

      If **Yes**, give details of the program:

PLEASE COMPLETE AND SIGN DISCLOSURE AUTHORIZATION & COMMUNICATION STATEMENT

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PART B – Employer Statement

This statement must be completed by the supervisor or timekeeper of the employer. If the insured is self-employed, the insured must complete the following statement in full.

1. Occupation of the insured/employee at the time of disability? _____
2. Employed how many days per week? ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ Sun
3. Average monthly earnings? $_____
4. Date employee last worked? _____/____/____ Hour: _____ ❑AM ❑PM
5. Date employee returned to work? _____/____/____ Hour: _____ ❑AM ❑PM ❑ Hasn't returned to work
6. Occupation of which the insured/employee returned to? _____

Company Name: _____

Company Address: _____
Address City State Zip Code

Supervisor/Timekeeper – Signature: _____

Printed Name: _____ Date Signed: ____/____/____

Official Position/Title: _____ Phone #: _____

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PART C - ATTENDING PHYSICIAN'S STATEMENT (*To Be Completed by Attending Physician*)

Patient Name: _____

1. **HISTORY**
   a. When did symptoms first appear or accident happen? ____/____/____
   b. Date patient ceased work because of disability? ____/____/____
   c. Has patient ever had same or similar condition? ❑ Yes ❑ No
      If **Yes**, state when and describe: _____
      _____
      _____
   d. Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown
   e. Names and addresses of other treating physicians:
      _____
      _____
2. **DIAGNOSIS** (Including any complications)
   a. Diagnosis: _____
   b. Subjective symptoms: _____
      _____
   c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)
      _____
3. **DATES OF TREATMENT**
   a. Date of first visit? ____/____/____
   b. Date of last visit? ____/____/____
   c. Frequency of visits? ❑ Weekly ❑Monthly ❑ Other: _____
4. **PROVIDE NATURE OF TREATMENT** (Including surgery and medications prescribed, if any)
   _
   _____
   Will treatment substantially improve function and employability? ❑ Yes ❑ No
5. **PROGRESS**
   a. Has patient: ❑ Recovered? ❑ Improved? ❑ Unchanged? ❑ Retrogressed?
   b. Is patient: ❑ Ambulatory? ❑ House confined? ❑ Bed confined?
6. **PHYSICAL IMPAIRMENT** (Check One)

❑ Class 1 – No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
❑ Class 2 – Slight limitation of functional capacity; capable of light manual activity. (15-30%)
❑ Class 3 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)
❑ Class 4 – Marked limitation. (60-70%)
❑ Class 5 – Severe limitation of functional capacity

Remarks: _____

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PART C - ATTENDING PHYSICIAN'S STATEMENT (*To Be Completed by Attending Physician*)(Continued)

7. MENTAL/NERVOUS IMPAIRMENT (If applicable)

- ❑ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ❑ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ❑ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ❑ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ❑ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ❑ Yes ❑ No

8. PROGNOSIS	**Patient's Job**		**Any Other Work**	
a. Is Patient now totally disabled?	❑ Yes ❑ No		❑ Yes ❑ No	
b. Do you expect a fundamental or marked change in the future?	❑ Yes ❑ No		❑ Yes ❑ No	
If **Yes,** when will patient recover sufficiently to perform duties?	___/___/___	❑ 1 Mo ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ Never	___/___/___	❑ 1 Mo ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ Never
If **No,** please explain:				
c. Date released to work:	___/___/___		___/___/___	
9. REHABILITATION	**Patient's Job**		**Any Other Work**	
a. Is patient a suitable candidate for trial employment?	❑ Yes ❑ No		❑ Yes ❑ No	
If **Yes,** when could trial employment start?	___/___/___	❑ FT ❑ PT	___/___/___	❑ FT ❑ PT
If **Yes,** what training will patient require?				
If **No**, please explain				
10. REMARKS				

_____/_____/_____

Signature (Attending Physician) Degree Date

Printed Name (Attending Physician) _____

Address: _____

Address City/Town State Zip

Phone: _____ Fax: _____

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 injure, 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.

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 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***