

Critical HealthEvents Claim

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 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.**

INSTRUCTIONS:

- **Section A & B:** These sections (including hospital information) must be completed by you, the policyholder. Please enclose any additional information that you feel will assist us in evaluating this claim.
- **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 & 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
- **Third Party Communication Authorization:** Complete if you would like us to discuss, release or provide information to others you designate regarding your claim.

SECTION A

Policyholder Information			Policy Number(s)			Patient Information			Check One <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self		
Name (First, Middle, Last)	<input type="checkbox"/> Male	<input type="checkbox"/> Female				Name (First, Middle, Last)	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Address (Street)	<input type="checkbox"/> Check here if NEW address	Apt #				Address (Street)	<input type="checkbox"/> 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. ()				
E-mail Address						E-mail Address					
Employer’s Name						Employer’s Name					
Employee of Trustmark Companies?: <input type="checkbox"/> Yes <input type="checkbox"/> No						Employee of Trustmark Companies?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish						Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish					

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 within the last ten years. You may attach a separate piece of paper for this information.

Critical HealthEvents Claim

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

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 / /

Information Pertaining to Premiums

In order to prevent the loss of your insurance coverage and to allow payment of benefits due, it is necessary to have any premiums due paid appropriately.

For the coverage under which benefits claimed:

If premium is more than 30-days behind your claimed date of loss, past due premiums will be deducted from any benefits paid.

For any other coverage through Trustmark:

As a service to you, we can withhold premiums for your benefits for any other insurance coverage you may have through Trustmark for as long as you are receiving payments. Please indicate below which you would prefer regarding your premium payments (*please note that this service is not available if premium is paid via payroll deduct on a pre-tax basis*):

- Yes** – please maintain my Trustmark coverage(s) in force by withholding premiums while I am receiving benefit payments.
- No** – I will make the payment myself, as needed, to maintain coverage(s).

OVERPAYMENT

If I receive benefit 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 benefit payments, to the extent allowed by law, in order to recover any overpayment balance that is not returned.

Date Signed: ____/____/____ Insured's Signature: _____

Date of Birth: ____/____/____ Relationship, if other than insured: _____

Fraud Statement for New York Residents: 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

Signature of Claimant X _____ Please Print Name _____

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

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.

Critical HealthEvents Claim

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

ATTENDING PHYSICIAN'S STATEMENT – CRITICAL ILLNESS			
PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION			Your Patient's Acct #:
1. Patient's Name (First, MI, Last)		Patient's SSN:	Patient's DOB: / /
2. Patient's Address (Street, City, State, Zip)			
3. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
5. Date of Diagnosis / /	6. Date 1 st consulted you for this condition / /	7. Has patient previously had same or similar condition: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, show 1 st 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 or injury:			
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	
<input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS)(Lou Gehrig's Disease)		Medical reports, Neurological reports	
<input type="checkbox"/> Benign Tumor		Medical Documentation	
<input type="checkbox"/> Other Condition Description:		Medical Documentation to support diagnosis	
Cancer			
Tissue/Organ of Origin:	Stage:	Grade:	Pathology Report
<input type="checkbox"/> Carcinoma in situ		Pathology report and/or Clinical Diagnosis	
<input type="checkbox"/> Leukemia		Clinical Diagnosis	
<input type="checkbox"/> Coronary Artery Obstruction - % occluded:		Coronary angiography report	
<input type="checkbox"/> Coronary Artery Bypass Surgery		Open heart surgical report	
<input type="checkbox"/> Coronary Artery Disease		Medical Documentation	
<input type="checkbox"/> Heart Attack		Any of the following: Electrocardiogram (EKG), Cardiac enzymes, Thallium scans, MUGA scans, Stress Echocardiogram	
<input type="checkbox"/> Major Organ Transplant		Surgical Reports	
<input type="checkbox"/> Stroke		Documented neurological deficits and/or neuroimaging studies	
<input type="checkbox"/> Transient Ischemic Attack (TIA or RIND)		Clinical Exam Diagnostic Evaluation	
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.			
Attending Physician -Print or Type Name		Degree	Medical Specialty
Street Address		Telephone #	Fax #
City	State	Zip Code	SSN or Employer's ID #:
Signature of Physician			Date Signed / /
Are you, the physician, related to this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the relationship?		May we communicate with you via email? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Email Address: _____	

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

State Required Fraud Warnings

Fraud Statement for Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma Residents, as well as for Residents of all States not Specifically Listed: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud, which is a crime."

Fraud Statement for Arizona Residents: For your protection, Arizona law requires the following statement 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 Arkansas, Louisiana, New Mexico, Rhode Island, 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 California 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 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 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 District of Columbia, Maine, Tennessee, Virginia and Washington 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 Statement for Florida 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 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.

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 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 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 Statement for Oregon Residents: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing materially false or misleading information may be guilty of insurance fraud.

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.

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

DISCLOSURE AUTHORIZATION

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 duration of the claim or up to 12 months from the date shown, 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 KS – this Authorization will be inforce for the duration of the claim or up to one (1) year, whichever comes first.

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.

Fraud Statement for New York Residents: 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

Date Signed: ____/____/____ Insured's Signature: _____

Date of Birth: ____/____/____ Relationship, if other than insured: _____

For Claims Customer Service:

Phone: 877-201-9373 x45708

For Claims Submission:

Fax: (508) 853-2757

Email: VBS_Disability@Trustmarkins.com

Insured Statement of Claim – 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 may 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, clutter, junk 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.

Should you prefer to submit your claims or claims information by U.S. Mail rather than email or fax, please use the following address: Trustmark Insurance PO Box 60676, Worcester, MA 01606

Authorization

I may revoke or update this authorization in writing at any time or by email to VBS_Disability@trustmarkins.com.

This authorization is valid for 24 months. 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

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

Third Party Communication Authorization

Please complete this authorization if you would like us to discuss, to release, or to provide information to a third party regarding benefits under your policy. Note: Policy Owner and Claimant must give permission for disclosure of their information to each other, if applicable.

Policy Owner Name: _____

Claimant Name: _____

Policy Number(s): _____

Name & Relationship of Third Party Representative: _____

- All information (all policy and claim information)
- Only the following information*: _____

Name & Relationship of Third Party Representative: _____

- All information (all policy and claim information)
- Only the following information*: _____

My Agent: (Name of Agent) _____

- All information (all policy and claim information)
- Only the following information*: _____

My Employer: (Name of Agent) _____

- All information (all policy and claim information)
- Only the following information*: _____

*Restrictions may include a restriction on certain types of information (such as not sharing financial, medical or health information).

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 or state regulations governing the privacy of health information relative to my condition.

I may revoke and update this authorization in writing at any time or by email to VBS_Disability@trustmarkins.com. This authorization is valid for 24 months. I may request a copy of this authorization and a copy is as valid as the original.

Signature of Policy Owner

Signature of Claimant (If someone other than the Policy Owner)

Printed Name

Printed Name

_____/_____/_____
Date

_____/_____/_____
Date



Best Doctors[®]

A Benefit of Trustmark Critical Illness and Critical HealthEventsSM Insurance



What does peace of mind mean to you?

Trustmark Critical Illness and Critical HealthEventsSM insurance policies offer strong protection against the financial impact of critical illnesses – but that’s not all. If you have one of these policies, you automatically have access to **Best Doctors[®]** at **no extra cost to you!** You and your covered family members can:

- Have the nation’s top expert physicians work with you on any medical question or condition you may have.
- Confirm that your diagnosis is correct or get a second opinion
- Ask questions to better understand your treatment options
- Find a highly skilled specialist for any condition
- Know that the treatments you’re paying for are right for your situation

“It’s knowing I’m getting the best possible medical care.”



Need expert medical advice? It’s easy:

1. Log on to bestdoctors.com or call us toll-free at 866-904-0910
2. Discuss your concerns in a comprehensive interview with a medical professional
3. Sign a release so they can access your medical data
4. Get a confidential report and review it with your Best Doctors clinician

You care. We listen.

Trustmark
Voluntary Benefit Solutions[®]

PERSONAL. FLEXIBLE. TRUSTED.™

Remember, this valuable benefit is **FREE** for Trustmark Critical Illness and Critical HealthEvents policyholders, so take advantage!

Log on to bestdoctors.com or call toll-free at 866-904-0910

Best Doctors[®]

A Benefit of Trustmark Critical Illness
and Critical HealthEventsSM Insurance

Best Doctors is **FREE to you**
with Trustmark Critical Illness or
Critical HealthEventsSM.

Log on to **bestdoctors.com** or
call toll-free at **866-904-0910**

Five ways Best Doctors can help Trustmark policyholders and covered family members:

- 1. FindBestDoc[®]**
When you need a doctor or specialist, start with the Best Doctors in America[®] – a database of over 50,000 of the world's top physicians.
- 2. Expert Second Opinion**
Confirm your diagnosis or treatment plan. Use Best Doctors for any medical condition – not just a critical illness.
- 3. Critical Care Support**
If you're admitted to the hospital with an acute illness, trauma or emergency, Best Doctors immediately gets experts involved and works with your local treatment team. It's like having your own personal medical concierge.
- 4. Ask the Expert[™]**
When you have a question about symptoms, medical conditions or treatment options, an expert takes the time to listen and respond to your concerns.
- 5. Medical Records eSummary[™]**
When you need your medical records, Best Doctors collects and organizes them and creates a Health Alert Summary for you on a USB drive or secure digital file.

Your Best Doctors membership connects you to better care.

A second set of eyes is always beneficial, and most doctors find value in additional information and confirmation of treatments. In fact, a Best Doctors analysis uncovered the following rates of misguided care in medical cases.



Wrong treatments
72% of the time



Surgery inappropriately
recommended in **38%**
of surgical cases



Insufficient medical
work-ups reported in
31% of cases



Misinterpretation of
pathology or diagnostic tests
in **23%** of cases of cases

You care. We listen.

Trustmark
Voluntary Benefit Solutions[®]
PERSONAL. FLEXIBLE. TRUSTED.[®]

Remember, this valuable benefit is **FREE** for Trustmark Critical Illness
and Critical HealthEvents policyholders, so take advantage!
Log on to **bestdoctors.com** or call toll-free at **866-904-0910**