Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Disability Benefits 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 & the Policyholder and be returned promptly for consideration of benefits. All questions and sections 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.**

Section A – Insured's Information

Policy / Certificate #: _____

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____
Street City State Zip Code

Phone #_____ ❑Home ❑Cell ❑Work E-Mail Address: _____

Gender: ❑ M ❑ F Height: _____ Weight: _____ Spouse's Name: _____

Language Preference: ❑ English ❑ Spanish

Section B – Claim Information

Is your disability due to: ❑ Accident/Injury ❑ Sickness When did your disability begin? ___/___/___

Please describe where & how your disability occurred & what illness/injury resulted: _____

_____

_____

Have you had a similar illness / injury? ❑ Yes ❑ No If yes, date(s): _____

Date of first treatment by a physician for this condition: ___/___/___

Name & Address of physician or hospital who first treated you for this condition:

_____
Physician Name Address Dates

_____
Physician Name Address Dates

_____
Physician Name Address Dates

If hospitalized, provide dates & name of hospital:

Dates Confined: From: ___/___/___ To: ___/___/___ Hospital: _____

I was unable to work From: ___/___/___ To: ___/___/___

I returned to work in a limited capacity From: ___/___/___To: ___/___/___

List any Physicians, Surgeons & Health Care Providers who attended to you and/or Pharmacies you have utilized during the past three (3) years. Please attach additional sheets, if needed.

_____
Name Address Reason

_____
Name Address Reason

List any periods of hospitalization you have had during the past three (3) years:

_____
Hospital Name Dates of Hospitalization

_____
Hospital Name Dates of Hospitalization

Please be sure all portions of claim form are completed as directed

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Insured's Name: _____ Policy #: _____

Please indicate any benefits that you are eligible to receive:

Source	Amount	Date Applied	Date Payments Began	Date Payments End
State Disability	$	___/___/___	___/___/___	___/___/___
Social Security	$	___/___/___	___/___/___	___/___/___
Worker's Comp	$	___/___/___	___/___/___	___/___/___
Unemployment	$	___/___/___	___/___/___	___/___/___
Retirement/Pension	$	___/___/___	___/___/___	___/___/___
Other_____	$	___/___/___	___/___/___	___/___/___

If you have other disability insurance coverage, please complete the information below:

Company Name	Policy #	Benefit Amount Per Month	Effective Date of Coverage

Section C – Information Needed For Withholding & Reporting Taxes (*This Section Must Be Completed*)

Do you pay your premiums through your personal credit union or other checking account: ❑ Yes ❑ No

If yes, please disregard the following four questions. If no, you must complete the following for questions.

% of Trustmark Premium Paid By Employer: _____%

If % above is more than 0% - Is the Employer Paid Premium Added to Employee's Income? ❑ Yes ❑ No

% of Trustmark Premium Paid By Employee: _____%

If % above is more than 0% - Is Employee Portion of Premium Paid with: ❑ Pre-Tax Dollars ❑ Post-Tax Dollars

Percentages must total 100%. If this section is not completed, Trustmark will assume 100% of premium is paid by employer and that the premium was not added to the employee's income. FICA taxes will be calculated accordingly.

Section D – 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).

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Section E – Insured's Statement of Claim – Employment Verification

(Please be advised that these statements may be confirmed with your Employer)

Employee Name: _____

Employer Name: _____

Employer Address: _____

Were you employed at the time of your impairment? Yes ❑ No ❑

Hours worked during the week: _____ Full Time? Yes ❑ No ❑ # of hours worked in a normal week: _____

Check regular work schedule: S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S ❑

Annual income prior to disability: Total $_____ Base: $_____ O/T: $_____

How often were you paid? Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑

Do you want your monthly disability benefit amount pro-rated & paid out to match the frequency of your pay check? Yes ❑ No ❑

Hire Date: ___/___/___ Date you last worked: ___/___/___

If terminated: Date ___/___/___Resigned ❑ Dismissed ❑ Laid Off ❑

Is your present condition the result of an accident or injury on the job? Yes ❑ No ❑

If yes, date of accident: ___/___/___ Have you filed a Workers Compensation Claim? Yes ❑ No ❑

Occupation Title(s):_____

Nature of employer's business: _____

Supervisor's Name: _____ Years with employer: _____

Years in occupation: _____ If retired, retirement date: ___/___/___

Please provide a description of your occupation to include your important duties (*attach separate sheet if necessary*)

Duty: _____

Duty: _____

Duty: _____

Duty: _____

Please explain how your condition has interfered with the performance of your job. Please be specific.

_____

_____

_____

Employer Human Resource Contact Information:

Name: _____ Title: _____

Telephone: (_____) _____ Fax: (_____) _____

Please attach a copy of your most recent pay stub (Prior to Disability)

Please sign & date Disclosure Authorization

Please be sure all portions of claim form are completed as directed

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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.

Please be sure all portions of claim form are completed as directed

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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.

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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: _____

Please be sure all portions of claim form are completed as directed

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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***

Please be sure all portions of claim form are completed as directed

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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

Please be sure all portions of claim form are completed as directed

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Name of insured: _____ Date of Birth: ____/____/____ SSN: _____

Attending Physician Statement *(To be completed by the physician)*

Date patient ***1st reported symptoms*** or accident happened: ___/___/___

Date patient ***advised to stop working*** because of impairment: ___/___/___

Date of 1st treatment: ___/___/___ Date of subsequent treatments: ___/___/___, ___/___/___, ___/___/___

Is this condition due to: An Accident? ❑ A Sickness? ❑

Is the accident or sickness related to the patient's employment? Yes ❑ No ❑ Unknown ❑

Is condition due to Pregnancy? Yes ❑ No ❑ Est. Date of Delivery: ___/___/___ Actual Delivery Date: ___/___/___

Delivery Type: Vaginal ❑ C-Section ❑ If C-Section: Elective ❑ Non-Elective ❑

Did another physician refer this patient to you? Yes ❑ No ❑ If yes, please list name, address & specialty below:

_____
Physician Name Address Dates

Patient's Condition Primary diagnosis: _____

ICD 10 Code for diagnosis: _____

Subjective symptoms: _____

Clinical findings (including results of Xrays, EKG's, laboratory data, pertinent physical exam notes, etc.)

_____

Has patient been hospital confined? Yes ❑ No ❑ From: ___/___/___ To: ___/___/___

If Yes, Hospital Name: _____

Do you consider the patient to be completely unable to work in his/her occupation? Yes ❑ No ❑

If yes, please provide dates: From: ___/___/___ To: ___/___/___

If still completely unable to work, when do you expect patient will be able to return to his/her work duties?

1-3 mos. ❑ 3-6 mos. ❑ 6-12 mos. ❑ More than 12 mos. ❑

If patient is able to do some work, for what period will patient be restricted from his normal duties?

From: ___/___/___ To: ___/___/___

What are patient's current limitations: _____

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

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.

Physician's Name: (please print): _____

Specialty: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____ Date Signed: ___/___/___

May we communicate with you using email? Yes ❑ No ❑ Email Address: _____