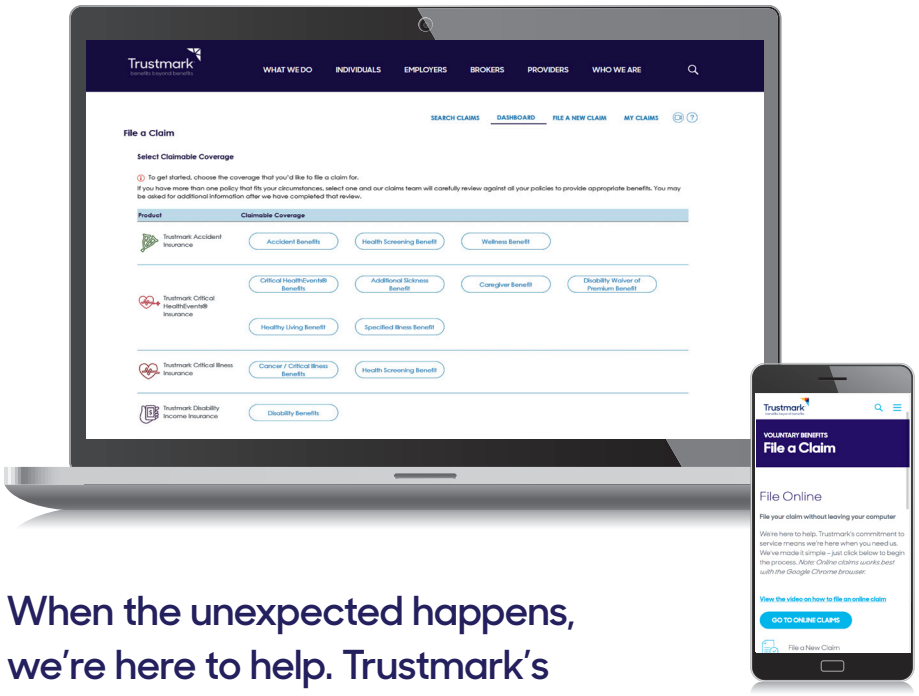
We've made it simple – you can file your Voluntary Benefits claim online.



When the unexpected happens, we're here to help. Trustmark's commitment to service means we're here when you need us.

TrustmarkVB.com/Claims

Underwritten by Trustmark Insurance Company and Trustmark Life Insurance Company of New York. Rated A- (EXCELLENT) A.M. Best

400 Field Drive • Lake Forest, IL 60045
TrustmarkVB.com

Trustmark
benefits beyond benefits

A112-2574 (2-20)

Whole Body Wellness Rider Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45704
For Claims Submission: 🖷 **Fax:** (508) 471-3208 ✉ **Email:** RiderClaimsVB@trustmarkbenefits.com

Instructions for Claim Submission

Please be sure to review the requirements noted below for claim submission and ensure your submission is complete to avoid any delays on your claim.

Please keep a copy of all parts of this form and any supporting documentation for your records.

Supporting Documentation

Required: Be sure to include the following required supporting documentation in your claim submission.

- Proof of treatment, such as copies of bills, invoices, explanation of benefits, treatment notes or test results that documents:
  - Date of test
  - Who test completed on
  - What specific test was completed

Claim Form

Required: Be sure to fully complete the following required portions of the claim form.
Incomplete or illegible answers may result in delay of benefits.

- Please complete a **SEPARATE** form for each individual and/or calendar year that you are claiming benefits.
- **Section A & B –** *To be completed by Policy Owner.* Complete these sections in full and return for review of benefits.
- **E-Sign Disclosure and Consent Notice** - *To be completed by Policy Owner.* Be sure to sign & date this section. Note texting as your preferred communication method if you would like to authorize Trustmark to alert you via text when any payment is process for this claim.
- **Disclosure Authorization** – *To be completed by patient unless patient is a minor or legally incapacitated.* Be sure to sign and date this section of the form, including DOB & last 4 digits of SSN where indicated.
- **Claim Submission Signature** – *To be completed by Policy Owner.* Be sure to sign and date this section of the form

Optional: These sections of the claim form are not required but completing them will provide better and faster communication with you or anyone you designate.

- **Consent for Use of Electronic Communication** - *To be completed by Policy Owner.* Complete if you would like claim communication by text or email, including text alerts for any payments released.
- **Third Party Communication Authorization** – *To be completed by Policy Owner & Patient (unless Patient is under 18 or legally incapacitated.)* Complete if you would like to authorize Trustmark to release information on your claim(s) to a third party such as a spouse, friend or agent

Informational: These sections of the claim form provide important information about your rights and the laws in each state.

- **State Required Fraud Language** - Attached for your information.

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Section A – Policy Owner Information *(To be completed by the Policy Owner)* Policy / Certificate #: _____

Name: _____ DOB: _____ SSN: _____

Address: _____
Street City State Zip Code

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

Employee of Trustmark Companies?: ❑ Yes ❑ No Language Preference ❑ English ❑ Spanish

Section B – Claim Information *(To be completed by the Policy Owner)* Please complete below and attach required proof of treatment which documents date of test, who test was completed on, and what test was completed, e.g. copies of outpatient bills, invoice or explanation of benefits.

Name of patient: _____ DOB: _____ SSN: _____

Relationship to Policy Owner: ❑ Policy Owner ❑ Spouse ❑ Son/Daughter ❑ Other _____

Routine Services: Please advise which routine service you had completed by providing the date it was completed in the section below.

Routine Service	Date Completed	Routine Service	Date Completed
Routine Mammogram		Endoscopy of Lower Intestine	
Pap Smear for Women Over Age 18		Stool DNA Test	
Human Papillomavirus Vaccination (HPV)		Complete skin exam for cancer	
Prostate Specific Antigen (PSA)		CA125 (Blood Test for Ovarian Cancer)	
Colonoscopy		Ultrasound of blood vessels in neck	
Virtual Colonoscopy		EKG	

Annual Screening: Some select policies include coverage for Annual Screening(s). If your policy includes this coverage, please complete below if you are claiming one of the following:

Routine Service	Date Completed	Routine Service	Date Completed
Immunization/Vaccination		Blood test for A1C	
Lipid Panel (Blood test for fat & cholesterol in blood)		Vision Test	

Follow-Up to Routine Screening: Only complete this section if, as a result of one of the above covered ***routine*** services, the patient required and received a follow-up diagnostic test. All fields are required.

Date of Initial Routine Screening	Date of Follow-Up Diagnostic Test	Name of Follow-Up Diagnostic Test Completed

This is not a guarantee of payment. Benefits will be determined based on your policy provisions & the provisions of your Whole Body Wellness Rider.

Fraud Statement for the State of New York: 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.

Section C – Claim Submission Signature: Please sign, print your name and date below to certify to the accuracy of information provided.

_____ _____ _____
Policy Owner Signature Print Name Date

Wellness Clinic or No Proof of Treatment: This section only needs to be completed if the claimed testing was part of a wellness clinic sponsored by your employer OR you have no documentation of the date & type of test provided. *To be completed by the Medical Professional who completed the testing.*

_____ _____ _____
Signature of Medical Professional Print Name Date

Whole Body Wellness Rider Claim

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E-Sign Disclosure and Consent Notice

This E-Sign Disclosure and Consent Notice ("Notice") applies to all communications, as defined below, for services provided by Trustmark Companies and our affiliates ("Trustmark" or "We"). Under this Notice, communications you receive in electronic form from us will be considered "in writing."

By using Trustmark electronic and online services ("Electronic Services"), you acknowledge that your electronic signature is legally binding and shall be treated as a valid signature for all purposes.

In addition, by using Trustmark Electronic Services you consent to the entirety of this Notice and affirm that you have access to the hardware and software requirements identified below. You must review and accept the terms of these services. If you choose not to consent to this Notice or you withdraw your consent, you will be restricted from using Electronic Services.

PREFERRED METHOD OF COMMUNICATION

☐ Text Messages and Email - Please provide cell phone #: (____) - _____ - _____

☐ Only Email - Please confirm email address: _____@ _____

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.

You understand that by selecting text messaging, regular text messaging rates may apply for any texts you receive from Trustmark and you assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked by notifying Trustmark.

COVERED COMMUNICATIONS

Includes, but is not limited to disclosures or communications we provide to you regarding our services such as: (i) claim submissions, third party authorizations, overpayment authorizations, fraud notices, terms and conditions, privacy statements or notices and any changes thereto; and (ii) customer service communications (such as claims of error communications) ("Communications").

METHODS OF PROVIDING COMMUNICATIONS

We may provide Communications to you by email or by making them accessible on the Trustmark websites, mobile applications, or mobile websites (including via "hyperlinks" provided online and in e-mails). Communications will be provided online and viewable using browser software or PDF files.

HARDWARE AND SOFTWARE REQUIREMENTS

To access and retain electronic Communications, you must have:

- A valid email address;
- A computer, mobile, tablet or similar device with internet access and current browser software and computer software that is capable of receiving, accessing, displaying, and either printing or storing Communications received from us in electronic form;
- Sufficient storage space to save Communications (whether presented online, in e-mails or PDF) or the ability to print Communications.

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We may request that you respond to an email to demonstrate you are able to receive these Communications.

HOW TO WITHDRAW YOUR CONSENT

You may withdraw your consent to receive Communications under this Notice by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733" Your withdrawal of consent will cancel your agreement to receive electronic Communications, and therefore, your ability to use our Electronic Services.

REQUESTING PAPER COPIES OF ELECTRONIC COMMUNICATIONS

You may request a paper copy of any Communications; we will mail you a copy via U.S. Mail. To request a paper copy, contact us by writing to "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733." Please provide your current mailing address so we can process this request. Trustmark may charge you a reasonable fee for this service.

UPDATING YOUR CONTACT INFORMATION

It is your responsibility to keep your primary email address current so that Trustmark can communicate with you electronically. You understand and agree that if Trustmark sends you a Communication but you do not receive it because your primary email address on file is incorrect, out of date, blocked by your service provider, or you are otherwise unable to receive electronic Communications, Trustmark will be deemed to have provided the Communication to you; however, we may deem your account inactive. You may not be able to transact using our Online Services until we receive a valid, working primary email address from you.

If you use a spam filter or similar software that blocks or re-routes emails from senders not listed in your email address book, we recommend that you add Trustmark to your email address book so that you can receive Communications by e-mail.

You can update your primary email address or other information by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733.

FEDERAL LAW

You acknowledge and agree that your consent to electronic Communications is being provided in connection with a transaction affecting interstate commerce that is subject to the federal Electronic Signatures in Global and National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct business with you by electronic means.

TERMINATION/CHANGES

We reserve the right, in our sole discretion, to discontinue the provision of your Communications, or to terminate or change the terms and conditions on which we provide Communications. We will provide you with notice of any such termination or change as required by law.

Authorization

I may revoke or update this authorization at any time by notifying Trustmark.
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 ***Last 4 of SSN***

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State Required Fraud Language

Fraud Statement for the states of Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma, as well as for all other 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 the state of Arizona: 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 the states of Arkansas, Louisiana, New Mexico, Rhode Island, Texas and West Virginia: 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 the state of California: 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 state of Colorado: 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 Policy Owner or claimant for the purpose of defrauding or attempting to defraud the Policy Owner 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 and the states of Maine, Tennessee, Virginia and Washington: 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 the state of Florida: 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 the state of Kentucky: 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 the state of Maryland: 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 the state of New Hampshire: 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, as provided in RSA 638:20.

Fraud Statement for the state of 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 the state of Oregon: 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 the state of Pennsylvania: 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.

Whole Body Wellness Rider Claim

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DISCLOSURE AUTHORIZATION

Insured's name (Patient) (*Please Print***):** _____ **Last 4 of SSN#**_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care 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 any information as treatment, consultations, examinations, tests or information otherwise needed to determine policy claim benefits due me.

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 (or my authorized representative) may request a copy. 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 information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality**.** I understand that I may request a record of redisclosure of any information.

Patient Signature (or Policy Owner, if Patient is under 18): _____

Signed by: ☐ Policy Owner ☐ Patient Date Signed: _____ Patient's Date of Birth: _____

Relationship, if other than insured: _____

Whole Body Wellness Rider Claim

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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 any policy and/or claim for benefits under your policy. Note: Policy Owner and Claimant (if appropriate) must give permission for disclosure of their information to each other, if applicable.

Policy Owner Name:_____ **SSN**:_____

Claimant Name (if appropriate): _____

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 policy and/or 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 address noted above. I understand that this authorization is valid until my revocation or until I complete a new authorization. Any new authorization will effectively revoke this authorization and replace it.

_____ _____

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

_____ _____

Printed Name | Printed Name

_____ _____

Date | Date