Life Waiver of Premium Continuance Claim

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Section A – Claimant's Information *(To be completed by Policy Owner)*

Policy / Certificate #: _____

Name: _____ DOB: _____ SSN: _____

Address: _____
Street City State Zip Code

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

Language Preference: English ☐ Spanish ☐ New Address Info? Yes ☐ No ☐

Section B – Claim Information *(To be completed by Policy Owner)*

For ***physical impairments***, please check ***one*** of the following which most closely describes your current level of impairment.

☐ I do not have a functional limitation. I am capable of heavy physical activity. I have no restrictions
☐ I am capable of medium manual activity
☐ I have a slight functional limitation. I am capable of light manual activity
☐ I have a moderate functional limitation. I am capable of clerical / administrative or sedentary activities
☐ I have a severe limitation of functional capacity. I cannot perform any activities

For ***mental/nervous*** impairments, please check ***one*** of the following which most closely describes your current level of impairment.

☐ I am able to function under stress & engage in interpersonal relations (no limitations)
☐ I am able to function in most stress situations & engage in most interpersonal relations (slight limitations)
☐ I am able to engage in only limited stress situations & engage in only limited interpersonal relations (moderate limitations)
☐ I am unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ I am unable to engage in any personal or social situations or endure any stress (severe limitations)

Please explain how your condition continues to prevent you from performing your occupation duties:

_____

_____

Please provide a brief description of your present daily activities: _____

_____

Have you been hospitalized since last report? ☐ Yes ☐ No

If yes, dates of confinement: From:_____To: _____

If yes, Name & Address of Hospital: _____

Have you been treated by a physician, therapist, counselor, etc., in addition to your attending physician? ☐ Yes ☐ No

If yes, please provide name(s) and address(es): _____

Have you retired from your employment? ☐ Yes ☐ No If yes, Date of Retirement: _____

Has your employment been terminated? ☐ Yes ☐ No If yes, Date of Termination: _____

I returned to my job working no more than 50% of my regular schedule From:_____To:_____

Are you doing any work for pay or benefits? ☐ Yes ☐ No

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Section B – Claim Information *(Continued)*

Are you receiving benefits from any of the following plans? If yes, please list the amount of benefit & company/carrier, if applicable. If no, please check "no":

Type of Benefit	Receiving?	Amount of Benefit	Name of Insurance Company or Carrier (If Applicable)
Worker's Compensation	Yes ☐ No ☐	$	
Salary Continuance	Yes ☐ No ☐	$	
Retirement	Yes ☐ No ☐	$	
Social Security – Self	Yes ☐ No ☐	$	
Social Security – Spouse	Yes ☐ No ☐	$	
Social Security – Child	Yes ☐ No ☐	$	
Long Term Disability	Yes ☐ No ☐	$	
Other (please identify plan)	Yes ☐ No ☐	$	
List all other sources of income:			

Please remember to:

- Sign & date Disclosure Authorization section
- Sign & date Claim Submission Signature section
- Have your physician complete the ***Attending Physician Statement*** (if applicable)

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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 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 the 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 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 the 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.

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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, 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 (or my authorized representative) may request a copy. I understand that 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 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: _____

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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:_____

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 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

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Claim Submission Signature

The statements made by me on this claim are true and complete. I have read and understand the fraud notices contained in this form.

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.

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

Signature of Policy Owner: _____ Print Name: _____

Date signed: _____

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Name of patient:_____Date of Birth:_____

Attending Physician Statement (Page 1 of 2) *(To be completed by the physician)*

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.

Patient's Condition Date of initial assessment:_____Current work status: _____

Current Primary DX causing impairment:_____ICD 10 Code: _____

Contributing DX's: _____

Subjective symptoms: _____

If condition due to Pregnancy: Est. Date of Delivery:_____Actual Date of Delivery: _____

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

Have you treated this patient for related conditions in the past? Yes ☐ No ☐ If Yes, describe intervention/timeframe and outcome: _____

Has patient been hospital confined? Yes ☐ No ☐ From:_____ To: _____

If Yes, Hospital Name: _____

Is patient able to do some work, but cannot work more than 50% of their regularly scheduled job? Yes ☐ No ☐
If yes, for what period of time do these restrictions limit the patient? From:_____ To: _____

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

Treatment

Date of 1st visit: _____ Date of last visit: _____ Frequency: Weekly ☐ Monthly ☐ Other: _____

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Name of patient:_____Date of Birth:_____

Attending Physician Statement (Page 2 of 2) *(To be completed by the physician)*

Have you referred patient to any other physicians? If so, please provide name(s) and address(es):

_____

_____

Nature of treatment, including medications: _____

_____

Status Patient has: Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed ☐

I) **Impairment** Describe objective evidence for loss of physiologic, mental or anatomic function. Include pertinent results of physical exam & diagnostics:

_____

_____

II) **Restrictions** (activities patient should not perform) and **Limitations** (activities patient cannot perform) based on documented **impairment(s)**:

_____

_____

III) **Disability** Based on my answers to section I & II above, my knowledge of the physical & mental requirements of my patient's job, and my knowledge & experience as a provider, I certify:

☐ 1) Total inability to work from_____to_____with a prognosis to return to work on_____**OR**

☐ 2) Partial inability to work from_____to_____with a prognosis to return to work on_____**OR**

☐ 3) I refrain from making a certification regarding work capacity at this time.

IV) **Additional Comments:**

_____

_____

_____

Physician's Name: (please print): _____

Specialty:_____

Address: _____

Phone: _____ Fax: _____

Signature:_____ Date Signed: _____

Please provide name & phone number for Office Manager or other person to contact if additional information is needed:

Name: (please print):_____ Phone: _____

Please attach copies of all medical records relating to the claim condition including treatment notes & test results.

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