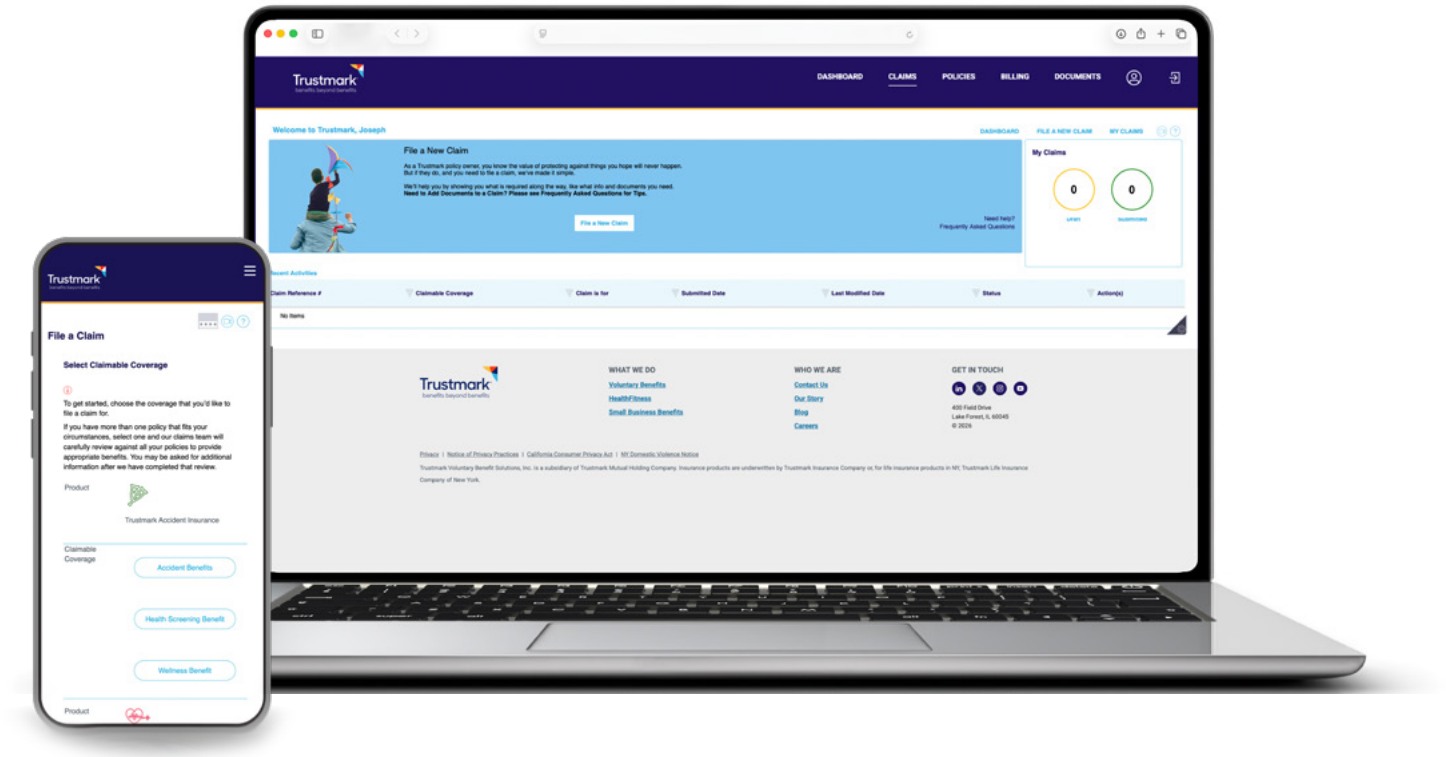
We've Made It Simple

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



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400 Field Drive
Lake Forest, IL 60045
TrustmarkVB.com

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A112-2574 (09-26)

Wellness Claim Form

Section A - Policy Owner Information (To be completed by the Policy Owner)

Policy / Certificate #:

SSN:

Name:

DOB:

Address:

Street | City | State | Zip Code

Phone Number:

☐ Home ☐ Cell ☐ Work

Email:

Trustmark Employee? ☐ Yes ☐ No

Section B - Patient / Claim Information (To be completed by the Certificate Owner)

Patient Name:

DOB:

SSN:

Relationship to Policy Owner:

☐ Policy Owner ☐ Spouse ☐ Child ☐ Other:

Section C - Routine & Preventive Services

Service	Date Completed	Service	Date Completed
Routine Mammogram		Virtual Colonoscopy	
Breast Ultrasound		Stool DNA Test	
Pap Smear (Women age 18+)		Endoscopy of Lower Intestine	
Prostate Specific Antigen (PSA)		Complete Skin Exam for Cancer	
Colonoscopy		Routine Physical	

Cardiac & Imaging Services

Service	Date Completed	Service	Date Completed
Chest X-Ray		Thermography	
EKG / ECG		Ultrasound of Blood Vessels in Neck	
Heart Exercise / Stress Test			

Blood-Based Screening Tests

Service	Date Completed	Service	Date Completed
A1C		CA-125 (Ovarian)	
Cholesterol (Total / HDL / LDL)		CA 15-3 (Breast)	

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Wellness Claim Form

Blood-Based Screening Tests (Continued)

Service	Date Completed	Service	Date Completed
Triglycerides		CEA (Colon)	
Genetic Blood Test (BRCA1 / BRCA2)		Serum Protein Electrophoresis	
Lipid Panel			

Other Services

Service	Date Completed	Service	Date Completed
Vision Test		Bone Marrow Testing	

Immunizations / Vaccinations

Vaccine / Immunization	Date Completed

Section D - Follow-Up Diagnostic Testing

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

Section E - Wellness Clinic or No Proof of Treatment

Complete only if services were provided at a workplace wellness clinic or proof is unavailable.

Field	Entry
Medical Professional Signature	
Printed Name	
Date Signed	

Section F - Claim Certification

Policy Owner must sign and date below.

Field	Entry
Policy Owner Signature	
Printed Name	
Date Signed	

Trustmark®

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Wellness Claim Form

For Claims Customer Service: 877-201-9373 x45704 (Phone)
For Claims Submission: 508-471- 3208 (Fax) | RiderClaimsVB@trustmarkbenefits.com (Email)
P.O. Box 2906 Clinton, IA 52733 (Mail)

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 #:

☐ Email Only - 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 I receive from Trustmark and I 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 andconditions, 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.

Methods of Providing Communications

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.

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

Wellness Claim Form

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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 terminateor 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 can 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.

Signature _____ Date Signed _____

Printed Name:

Address:

Street _____ City _____ State _____ Zip Code _____

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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 New York: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In New York, civil penalty shall not exceed five thousand dollars and the stated value of the claim for each such violation.

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, pharmacy, pharmacy benefit manager, 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 certificate 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 certificate 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. Revoking my authorization will not affect any information already shared based on this authorization. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine certificate 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 certificate. 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 Certificate Owner, if Patient is under 18):

Patient Signature

Signed by: ☐ Certificate 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 certificate and/or claim for benefits under your certificate. Note: Certificate Owner and Claimant (if appropriate) must give permission for disclosure of their information to each other, if applicable.

Certificate Owner Name:

Patient Name:

Certificate Number(s):

Name & Relationship of Third Party Representative:

- ☐ All information (all certificate and claim information)
- ☐ Only the following information*:

Name & Relationship of Third Party Representative:

- ☐ All information (all certificate and claim information)
- ☐ Only the following information*:

My Agent: (Name of Agent)

- ☐ All information (all certificate and claim information)
- ☐ Only the following information*:

My Agent: (Name of Agent)

- ☐ All information (all certificate 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).

Third Party Communication Authorization

I agree that if I authorize release of all certificate 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 Certificate Owner Or Certificate Owner's Personal Representative's Signature

Printed Name

Date

Signature of Patient (If someone other than the Certificate Owner)

Printed Name

Date

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