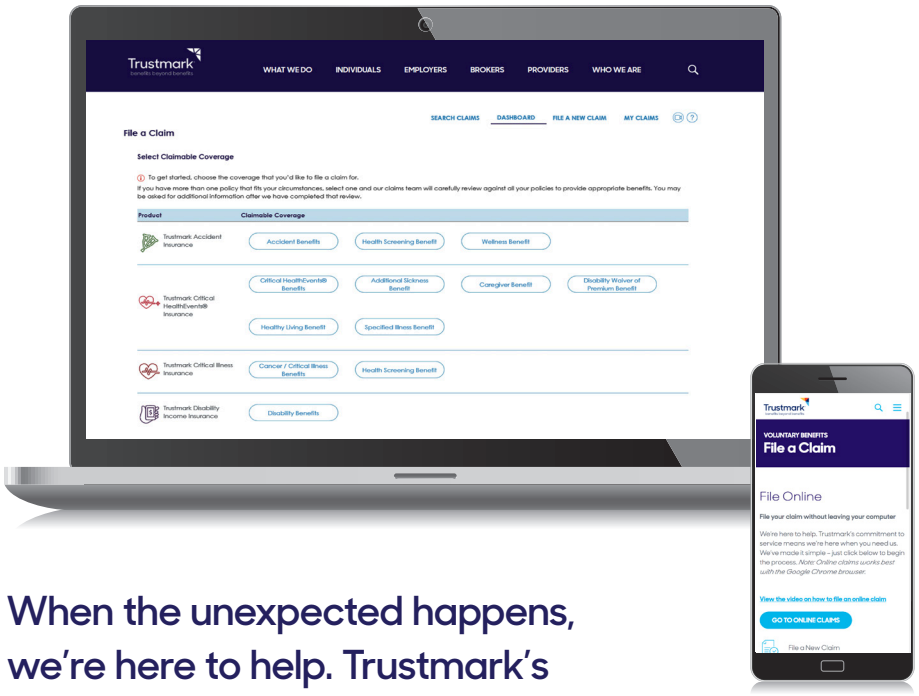
We've made it simple – you can file your Voluntary Benefits claim online.



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

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A112-2574 (2-20)

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Disability Benefits Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@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.

The Policy Owner is responsible for completion of all portions of this form without expense to Trustmark Insurance Company.

This is not a guarantee of payment. Benefits will be determined based on your policy provisions.

Supporting Documentation

Required: Be sure to include the following required supporting documentation in your claim submission.
- A copy of your most recent pay stub (prior to disability)

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.

- **Section A, B, C & D –** *To be completed by Policy Owner.* Complete these sections in full and return for review of benefits
- **Disclosure Authorization -** *To be completed by Policy Owner.* 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
- **Attending Physician Statement** – *To be completed by the Physician treating you.* Be sure to have them 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.* 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.

- **E-Sign Disclosure and Consent Notice** - Attached for your information.
- **State Required Fraud Language -** Attached for your information.

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Section A – Policy Owner Information *(To be complete by the Policy Owner)*

Policy / Certificate #: _____

Name: _____ DOB: _____ SSN: _____

Address: _____
Street City State Zip Code

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

Height: _____ Weight: _____ Language Preference: ❑ English ❑ Spanish

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

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

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

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

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Section B – Claim Information (Continued) *(To be complete by the Policy Owner)*

Policy Owner Name: _____ Policy #: _____

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 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 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 D – 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 remember to:

- **Include a copy of your most recent pay stub (Prior to Disability)**
- **Sign & date Disclosure Authorization section**
- **Sign & date Claim Submission Signature section**

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Disability Benefits 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.

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.

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, 100 North Pkwy, Worcester, MA 01605." 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, 100 North Pkwy, Worcester, MA 01605." Please provide your current mailing address so we can process this request. Trustmark may charge you a reasonable fee for this service.

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Disability Benefits Claim

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For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

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, 100 North Pkwy, Worcester, MA 01605.

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.

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State Required Fraud Warnings

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: 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 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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Disability Benefits Claim

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For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

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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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 by notifying Trustmark.

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 P.O. Box 2906, Clinton, IA 52733

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 Digits of SSN#***

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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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For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

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.

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? ❑ A Pregnancy? ❑

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

If condition due to Pregnancy: 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 Date of initial assessment: _____ Current work status: _____

Primary DX causing impairment: _____ ICD 10 Code: _____

Contributing DX's: _____

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: _____

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)**:

_____

_____

_____

Please be sure to complete all portions of Attending Physician Statement form including signature on 2nd page

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Name of patient: _____ Date of Birth: ____/____/____

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

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 inabliity to work from _____ to _____ with a prognosis to return to work on _____ **OR**

☐ 2) Partial inabliity 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:**

_____

_____

_____

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: _____

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: _____