TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK

126 South Swan Street, Suite 203
Albany, NY 12210

CLAIM FORM

INSTRUCTIONS: IN ORDER TO PROVIDE PROMPT SERVICE TO YOUR REQUEST FOR ACCELERATED DEATH BENEFIT UNDER THE CONVALESCENT CARE BENEFIT RIDER, COMPLETE PART I IN ITS ENTIRETY, **SIGN AND DATE THE AUTHORIZATION** AND HAVE YOUR PHYSICIAN COMPLETE PART II. COMPLETED CLAIM FORM SHOULD BE RETURNED TO: TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK, PO BOX 7962, LAKE FOREST, IL 60045-7962.
BENEFIT PAYMENTS MAY ONLY BE MADE IF THE PAYMENTS ARE SUBJECT TO FAVORABLE TAX TREATMENT BY THE FEDERAL GOVERNMENT. WHEN DETERMINING WHETHER THE BENEFIT PAYMENTS WILL RECEIVE FAVORABLE TAX TREATMENT, THE PAYMENT OF BENEFITS FROM ALL INSURANCE POLICIES MUST BE CONSIDERED.

PART I – STATEMENT OF THE INSURED (PLEASE PRINT OR TYPE)

POLICY NO. _____

INSURED'S NAME _____ DATE OF BIRTH _____ TELEPHONE NO. _____
(FIRST) (MIDDLE) (LAST) (AREA) (NO.)

SOCIAL SECURITY NO. _____

INSURED'S ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

EMPLOYER/SUPERVISOR _____ PHONE NO. _____
(NAME) (ADDRESS)

DATE LAST WORKED _____

BENEFIT(S) APPLIED FOR: ☐ LONG TERM CARE FACILITY BENEFIT ☐ ASSISTED LIVING BENEFIT ☐ HOME HEALTH BENEFIT
☐ ADULT DAY CARE BENEFIT

ARE YOU COVERED BY OTHER INSURANCE POLICIES THAT PAY SIMILAR BENEFITS? ☐ YES ☐ NO
IF YES, IS POLICY TAX-QUALIFIED? ☐ YES ☐ NO

NAME AND ADDRESS OF CARRIER

BENEFIT AMOUNT: ☐ PER DAY _____ ☐ PER MONTH _____

COMPLETE FOR HOME HEALTH CARE OR ADULT DAY CARE:

NAME AND ADDRESS OF AGENCY PROVIDING HOME HEALTH CARE

(NAME) (ADDRESS) (DATE OF SERVICE)

PHYSICIAN WHO IS CERTIFYING TO HOME HEALTH CARE/ADULT DAY CARE

(NAME) (ADDRESS) (DATE OF SERVICE)

LICENSED HEALTH CARE PROVIDERS CONSULTED OTHER THAN CERTIFYING PHYSICIAN, FOR PRESENT CONDITION:

(NAME) (ADDRESS) (PHONE NO.) (DATES)

NAME OF HOSPITAL _____ DATE ADMITTED _____ DATE DISCHARGED _____

DATE OF ACCIDENT/ILLNESS DESCRIPTION OF ACCIDENT/ILLNESS:

IS THIS A WORK-RELATED INJURY OR ILLNESS? ☐ YES ☐ NO PLACE OF ACCIDENT

NATURE AND EXTENT OF INJURY OR ILLNESS DATE OF FIRST TREATMENT

HAVE YOU HAD ANY OTHER MEDICAL ATTENTION IN THE PAST FIVE YEARS? ☐ YES ☐ NO. IF YES, PLEASE COMPLETE.

DOCTORS NAME ADDRESS PHONE NO.

DIAGNOSIS DATES OF TREATMENT

WHAT ACTIVITIES OF DAILY LIVING ARE YOU CURRENTLY UNABLE TO PERFORM WITHOUT ASSISTANCE?
BATHING ☐ CONTINENCE ☐ DRESSING ☐ EATING ☐ GOING TO THE TOILET ☐ TRANSFERRING ☐

IF SO, PLEASE EXPLAIN _____

IF PATIENT/INSURED IS INCOMPETENT, PLEASE PROVIDE NAME, ADDRESS, AND NOTARIZED PAPERS FOR GUARDIAN, CONSERVATOR, POWER OF ATTORNEY, OR TRUSTEE WHO IS RESPONSIBLE FOR FINANCIAL AFFAIRS.

NAME _____ ADDRESS _____

AUTHORIZATION — I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, OR OTHER ORGANIZATIONS, INSTITUTION OR PERSON WHICH MAY HAVE INFORMATION PERTINENT TO MY CLAIM, INSURANCE COMPANY OR CONSUMER REPORTING AGENCY, OR EMPLOYER HAVING ANY RECORDS OR INFORMATION PERTAINING TO ALL MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, EVALUATION, DIAGNOSIS, TREATMENT OR PROGNOSIS, SPECIFICALLY TO INCLUDE PSYCHIATRIC, COMMUNICABLE OR INFECTIOUS DISEASES, INCLUDING AIDS AND ANY OTHER NON-MEDICAL INFORMATION OF ME TO GIVE TO TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK (TRUSTMARK) OR ITS LEGAL REPRESENTATIVES, ANY AND ALL SUCH INFORMATION. I FURTHER ACKNOWLEDGE THAT THE INFORMATION OBTAINED BY USE OF THIS AUTHORIZATION WILL BE USED BY TRUSTMARK TO DETERMINE MY ELIGIBILITY FOR BENEFITS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION. I FURTHER AGREE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL, AND THAT SUCH AUTHORIZATION SHALL BE VALID FOR ONE YEAR FROM THE DATE SHOWN BELOW.

By signing this claim form you declare that your application for this benefit is voluntary and without coercion on the part of any third party.
No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Any 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, 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.

SIGNED _____ DATE _____
(INSURED)

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PART II – ATTENDING PHYSICIAN'S STATEMENT

Your prompt completion of all items on this form will help us help your patient

PATIENT'S NAME	AGE

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT)	DATE FIRST CONSULTED YOU FOR THIS CONDITION	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES AND DIAGNOSIS.

NAME & ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCES (e.g. PUBLIC HEALTH AGENCY)	HAS PATIENT ANY CHRONIC OR CONSTITUTIONAL DISEASE, PHYSICAL DEFECT OR DEFORMITY ☐ YES ☐ NO IF SO, DESCRIBE

PATIENT'S DIAGNOSIS (DX CODE):

THE PATIENT NEEDS ASSISTANCE WITH THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)
BATHING ☐ CONTINENCE ☐ DRESSING ☐ EATING ☐ GOING TO THE TOILET ☐ TRANSFERRING ☐

COGNITIVE IMPAIRMENT		**GOOD**	**FAIR**	**POOR**
A. SHORT TERM MEMORY		☐	☐	☐
B. LONG TERM MEMORY		☐	☐	☐
C. UNDERSTANDS & FOLLOWS SIMPLE DIRECTIONS		☐	☐	☐
D. ORIENTATION TO:	TIME	☐	☐	☐
	PLACE	☐	☐	☐
	PERSON	☐	☐	☐

DOES PATIENT SUFFER FROM ANY MENTAL, PSYCHONEUROTIC OR PERSONALITY DISORDER WITHOUT DEMONSTRABLE ORGANIC DISEASE?
☐ YES ☐ NO IF YES, PLEASE EXPLAIN. _____

TYPE OF SERVICE: ☐ LONG TERM CARE ☐ HOME HEALTH CARE ☐ ADULT DAY CARE

AGENCY PROVIDING HOME HEALTH CARE

NAME _____ ADDRESS _____ ZIP _____

PHONE NUMBER: _____ LICENSE NUMBER: _____

ADULT CARE CENTER

NAME _____ ADDRESS _____ ZIP _____

PHONE NUMBER: _____ LICENSE NUMBER: _____

COMPLETE FOR LONG TERM CARE:

NAME OF NURSING HOME: _____ PHONE (_____

ADDRESS: STREET _____ CITY _____ STATE _____ ZIP _____

TAX I.D. # _____

LICENSED BY THE STATE? ☐ YES ☐ NO LICENSE # _____
AS WHAT? (PLEASE CIRCLE) SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE ☐
RESIDENTIAL ☐ OTHER _____
(SPECIFY)

WHAT IS YOUR PROGNOSIS FOR RECOVERY AND/OR CESSATION OF TREATMENT? _____

EXPECTED LENGTH OF CONFINEMENT, SERVICE? FROM _____ TO _____

PLEASE PRINT

PHYSICIAN'S NAME AND DEGREE(S) _____ PHONE NUMBER: _____
AREA CODE NO.

ADDRESS: STREET _____ CITY _____ STATE _____ ZIP _____

I CERTIFY THAT THE ABOVE CONFINEMENT, CARE OR SERVICE IS MEDICALLY NECESSARY.

FULL SIGNATURE _____ DATE _____