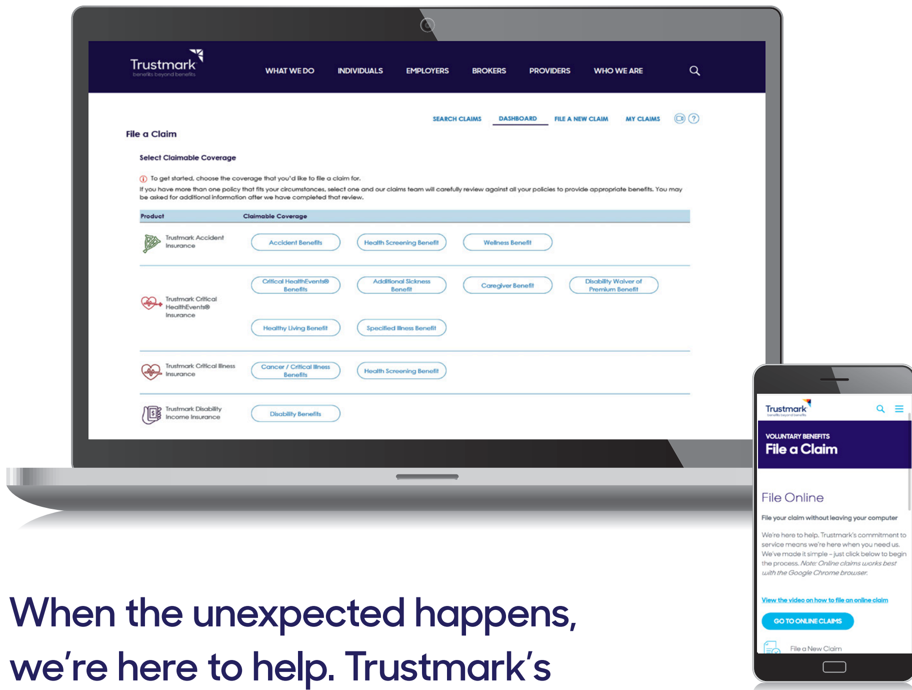
We've made it simple – you can file your Voluntary Benefits claim online.



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

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

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A112-2574 (2-20)

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Accident Claim

For Claims Customer Service: ☎ **Phone:** 877-201-9373 x45704
For Claims Submission: 🖷 **Fax:** (508) 853-2867 ✉ **Email:** AccidentClaimsVB@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.

Please be sure to include proof of treatment including itemized copies of any doctor, emergency room, hospital and motor vehicle incident/accident reports or records, complete hospital intake and discharge statement(s), UB-04 insurance billing form, HCFA or CMS 1500 billing form.

This is not a guarantee of payment. Benefits will be determined based on your policy provisions.
The Policy Owner is responsible for completion of all portions of this form without expense to Trustmark Companies.

Supporting Documentation

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

- Proof of treatment including medical records describing treatment date and diagnosis, complete hospital intake and discharge statement(s), itemized copies of any doctor, emergency room, and/or hospital bills, UB-04 insurance billing form, HCFA or CMS 1500 billing form.
- If surgery was done, please provide a copy of the operative report.
- If claiming a fracture, please include an imaging report, such as an x-ray, showing the fracture.
- For a laceration, please include the length of the operation and proof of stitches if received.
- For Lodging/Transportation benefit(s), please include copies of Mapping, such as Google Maps, to document mileage to facility/treatment, and hotel bills for lodging.
- If accident was the result of a MVA (motor vehicle accident), please provide complete copy of motor vehicle incident/accident police report.
- Other proofs of treatment may be needed.

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 –** *To be completed by Policy Owner*. Complete these sections in full and return for review of benefits.
- **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.

- **E-Sign Disclosure and Consent Notice** - *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.* 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 Notices** – Attached for your information.

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

Policy/Certificate#: ______________________ SSN Number (last 4 digits) ____________________

Name: ____ DOB: ______________

Address: ____
Street Apt #

____
City State Zip Code

Phone #______________________ ❑ Home ❑ Cell ❑ Work E-Mail Address:________________________________

Note: To authorize texting please complete the **E-Sign Disclosure and Consent Notice.**

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

Please complete below and attach supporting documentation outlined on the ***Instructions for Claim Submission*** page, as well as items as indicated throughout the form.

Name of patient: ______________________________________ DOB: ___________ SSN: ___________________

Relationship to Policyholder: ❑ Policyholder ❑ Spouse ❑ Child ❑ Other ____________________________

Date of accident: _____________ Diagnosis: ____

Please provide description of accident including where the accident occurred and what happened to the patient:

Is accident a result of a Motor Vehicle Accident (MVA)? ❑ Yes ❑ No *(If Yes, a copy of MVA report is needed)*

Did the accident occur while on the job? ❑ Yes ❑ No *(If Yes, a copy of work incident report is needed)*

Date of Initial Treatment	Where Treatment Received	Date of Follow-Up Visit	Where Follow-Up Treatment Received
	❑ Urgent Care ❑ Emergency Room (ER) ❑ Doctor's Office ❑ Other: ______________________		❑ Urgent Care ❑ Emergency Room (ER) ❑ Doctor's Office ❑ Other: ______________________

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Please provide information pertaining to first date of hospital confinement
Note: Room & Board Charge must be incurred. Confinement in a rehab facility is not a covered benefit.
ICU = Intensive Care Unit Observation Unit requires admission of at least 20 hrs.

Dates	Type of Room	
	❑ Regular ❑ ICU ❑ Observation Unit	Admission Time ________ Discharge Time _________

Please list all additional dates of confinement

Dates	Type of Room	Dates	Type of Room
	❑ Regular ❑ ICU ❑ Observation Unit		❑ Regular ❑ ICU ❑ Observation Unit
	❑ Regular ❑ ICU ❑ Observation Unit		❑ Regular ❑ ICU ❑ Observation Unit

Physical Therapy: Please complete below if you are claiming physical therapy. Physical Therapy must be performed by a licensed physical therapist. There is a maximum of 6 Physical Therapy visits per Covered Accident.

Date of initial physical therapy visit: ______________

Date(s) of Physical Therapy	Name of Facility	Address of Facility

Fracture or Dislocation: Please complete below if you are claiming a fracture or dislocation. Proof of diagnosis is required. If surgery was done the operative report is required.

Bone(s): _________________________ ________________________ _______________________

_________________________ ________________________ _______________________

Was surgery required? ❑ Yes ❑ No Date of Surgery ________________

Was anesthesia required? ❑ Yes ❑ No

Surgery: When a Covered Person undergoes Surgery as a result of a Covered Accident benefits may be payable depending on the surgery type. Please complete below if you are claiming a surgery benefit. (Copy of operative report is required)

Date of Surgery: ______________

Description of Surgery: ____

Name of Facility where surgery was completed:____

Address of Facility: ____

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Other Benefits: Please complete below for other benefits you are claiming.		
Air Ambulance Benefit	❑ Yes ❑ No	Please provide proof of transport
Ground Ambulance Benefit	❑ Yes ❑ No	Please provide proof of transport
Appliance Benefit	❑ Yes ❑ No	Please provide prescription for appliance (e.g. crutches, wheelchair, etc.)
Concussion Benefit	❑ Yes ❑ No	Please provide proof of diagnosis
Laceration	❑ Yes ❑ No	Please provide proof of length and repair (i.e. stitches), if applicable
Eye Injury	❑ Yes ❑ No	Please provide proof of surgery or the removal of foreign object
Burn Benefit	❑ Yes ❑ No	Please provide proof showing degree and % of body surface
Skin Graft	❑ Yes ❑ No	Please provide operative report
Blood/Plasma/Platelet	❑ Yes ❑ No	Please provide medical record
Emergency Dental	❑ Yes ❑ No	Please provide dental record showing treatment due to an accident
Transportation	❑ Yes ❑ No	Please provide proof of appointment and mileage
Lodging	❑ Yes ❑ No	Please provide proof of lodging and mileage
Loss of Finger/Toe/Foot/Sight	❑ Yes ❑ No	Please provide operative report or medical record
Prosthetic Device or Artificial Limb Benefit	❑ Yes ❑ No	Please provide proof of prescription and receipt
Accidental Death Benefit	❑ Yes ❑ No	Please provide death certificate, police report and autopsy
Accident Death-Common Carrier	❑ Yes ❑ No	Please provide death certificate, police report and autopsy
Catastrophic Accident Benefit	❑ Yes ❑ No	Please provide medical records showing total and irreversible loss of use

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.

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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 text, if selected) 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.

State Required Fraud Notices

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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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:____ **SSN:** ______________________________

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 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: _____________