Trustmark Voluntary Benefit Solutions
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Critical HealthEvents - Application for Waiver of Premium

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

This form must be completed by the Policyholder, Employer and Attending Physician for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible. Please keep a copy of this form and any attachments for your records. **The Policyholder is responsible for completion of all portions of this form without expense to Trustmark Insurance Company.**

Section A – Insured's Information *(To Be Completed By Insured)*

Policy / Certificate #: ___________________________

Name: ____ DOB: ____/____/____ SSN: ________________________

Address: ____
Street City State Zip Code

Phone #________________________ ❑Home ❑Cell ❑Work E-Mail Address: ____

Name & Address of Employer: ____ Date Employed ___/___/___

Occupation: _______________________________________ Principal Duties: ____

Employee of Trustmark Companies? ☐ Yes ☐ No Language Preference: ☐ English ☐ Spanish

Section B – Claim Information *(To Be Completed By Insured)*

Doctors Consulted		
Name	**Address**	**Dates**

Describe nature of illness or injury: ____

1. If ***Illness,*** on what date did you first notice the illness? ___/___/___
2. If ***Accident/Injury***, date occurred? ___/___/___ Where you at work? Yes ❑ No ❑

How did accident/injury happen? ____

____

3. Date you stopped working due to disability: ___/___/___
4. Date you resumed any work activity: ___/___/___
5. If you are not currently performing any work activity, what date do you expect to be able to return to work full or part time? ___/___/___
6. 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_____________	$	___/___/___	___/___/___	___/___/___

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Section B – Claim Information (Continued) *(To Be Completed By Insured)* **Policy #:** ________________

Please provide the following information concerning your education, prior occupations, hobbies, special skills, and interest in future employment.

	Question	Response
Education	What is the level of your education? How many years of grade school, high school, college, etc.?	
	Describe courses taken (commercial, vocational, academic, etc.) Any trade schools, military training schools, or other special training? If so, please describe.	
	Are you currently enrolled or attending classes or training toward a certificate, degree, continuing education requirement or certification?	
Prior Occupations	Attach resume or list & give details of all previous occupations for the prior 10 years. Specify ***all duties of each occupation*** and show beginning & end dates of employment (add additional sheets of paper if needed).	
Special Skills and Abilities	Identify equipment, tools, and machinery that you have used or operated in the past.	
Hobbies	Do you have any hobbies and/or other special interests (woodworking, mechanical repairs, painting, etc.)? If so, please describe in detail.	
Occupational Interests	Would some other employment interest you based on your past experience, hobbies, special training, etc.? If so, please describe in detail.	
Resuming Work	Have you participated in any type of work since your disability began? If so, give details including the type of work, the duties performed, when and where your work activity took place, including employer(s) name and address.	
Vocational Rehabilitation	Are you participating in a rehabilitation program? Yes ❑ No ❑ If ***Yes***, please describe details of the program.	

PLEASE COMPLETE & SIGN DISCLOSURE AUTHORIZATION & INSURED STATEMENT OF CLAIM – COMMUNICATION

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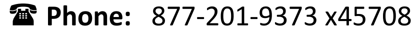
For Claims Customer Service: 
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Section C – Employer Statement

The below portion of this statement must be completed by the Supervisor / Human Resource Contact of the employer. If the insured is self-employed, the insured must complete the following statement in full.

Name of Employee: ____

Employer Name: ____

Employer Address: ____

Job Title: ____

Job Classification (please circle): Heavy Labor Moderate Labor Light Labor Sedentary/Clerical Labor

Job Duties (Please attach a job description. If no job description is available, please list job duties below):

____

____

____

____

Hours worked during the week: _____________

Yearly earnings: Total $__________ Base: $___________ O/T: $__________

Date employee last worked: ___/___/___ If terminated: Date ___/___/___

Reason Not Working (please circle): Sickness Injury Retired Resigned Dismissed Laid Off

Other: ____

Were job duties modified or hours reduced due to illness or injury prior to last day worked: ❑ YES ❑ NO

If yes, please describe: ____

Date employee returned to Regular Duties: FT: ___/___/___ P/T: ___/___/___

Date employee returned to Light Duties: FT: ___/___/___ P/T: ___/___/___

Occupation employee returned to: ___________________________________

❑ Has not returned to work

Supervisor/Employer Human Resource Signature: ____

Printed Name: _______________________________ Title: _____________________________

Date Signed: ___/___/___ Telephone: (_____) ________________ Fax: (_____) ___________________

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State Required Fraud Warnings

Fraud Statement for Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma Residents, as well as for Residents of 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 Arizona Residents: 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 Arkansas, Louisiana, New Mexico, Rhode Island, Texas and West Virginia Residents: 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 California Residents: 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 Colorado Residents: 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 District of Columbia, Maine, Tennessee, Virginia and Washington Residents: 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 Florida Residents: 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 Kentucky Residents: 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 Maryland Residents: 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 New Hampshire Residents: 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 New Jersey Residents: 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 Oregon Residents: 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 Pennsylvania Residents: 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 (*Please Print*): ____ **SS#** ___________________________

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 may request a copy. I understand that if I choose 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 any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Residents of CA – the first sentence of the AUTHORIZATION is changed as follows: 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 persons having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employees 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 or finances or information otherwise needed to determine policy claim benefits due me.

Residents of AZ - You or your authorized representative are entitled to receive a copy of this Disclosure Authorization.

Residents of KS – this Authorization will be inforce for the duration of the claim or up to one (1) year, whichever comes first.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

Residents of NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Fraud Statement for New York Residents: 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 Signed: ____/____/_____ Insured's Signature: ____

Date of Birth: ____/____/____ Relationship, if other than insured: ___________________________

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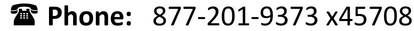
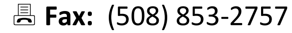
For Claims Customer Service: 

For Claims Submission: 

OVERPAYMENT

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.

Date Signed: ____/____/_____ Insured's Signature: ____

Date of Birth: ____/____/____ Relationship, if other than insured: ___________________________

Fraud Statement for New York Residents: 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 Claimant X _______________________________________ Please Print Name ___________________________________

The statements made by me on this claim are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices on the instruction page

Date Signed _____/_____/_____ Social Security Number _________________________

I signed on behalf of the claimant, as ___________________________ *(indicate relationship)*.
If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Critical HealthEvents - Application for Waiver of Premium

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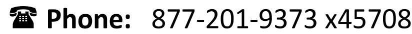
For Claims Customer Service: 

For Claims Submission:

Insured Statement of Claim – 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 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.

_______________________________ _______________________________

Policy Owner Signature ***Date***

_______________________________ _______________________________

Printed Name ***Social Security Number***

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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 benefits under your policy. Note: Policy Owner and Claimant 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 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 VBS_Disability@trustmarkins.com. 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 of Policy Owner

____
Signature of Claimant (If someone other than the Policy Owner)

____
Printed Name

____
Printed Name

_____/_____/_____
Date

_____/_____/_____
Date

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Name of insured: ______________________________________ Policy #_____________ Date of Birth: ____/____/____

Section D – Attending Physician Statement *(To be completed by Attending Physician)*

1. History

a. When did symptoms first appear or accident happen? ___/___/___

b. Date patient ceased work because of disability? ___/___/___

c. Has patient ever had same or similar condition? Yes ❑ No ❑ If Yes, state when and describe details:

____

d. Names & addresses of other treating physicians: ____

____

2. Diagnosis *(Including any complications)*

a. Diagnosis: ____

b. Subjective Symptoms: ____

____

c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

____

3. Dates of Treatment

a. Date of 1st visit? ___/___/___ b. Date of last visit? ___/___/___

c. Frequency of visits? ❑ Weekly ❑ Monthly ❑ Other: ______________________________

4. Provide Nature of Treatment *(Including surgeries, if any)*

____

____

____

____

____

____

____

____

____

____

Will treatment substantially improve functionality and employability? Yes ❑ No ❑

5. Current Medications (Including dosage and frequency)

____________________________________ Dosage _______________ Frequency_____________________

____________________________________ Dosage _______________ Frequency_____________________

____________________________________ Dosage _______________ Frequency_____________________

____________________________________ Dosage _______________ Frequency_____________________

____________________________________ Dosage _______________ Frequency_____________________

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Section D – Attending Physician Statement *(To be completed by Attending Physician)**(Continued)***

6. Physical Impairment *(Check One)*

- ❑ **Class 1** – No limitations of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- ❑ **Class 2** – Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- ❑ **Class 3** – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)
- ❑ **Class 4** – Marked limitation. (60-70%)
- ❑ **Class 5** – Severe limitations of functional capacity

Remarks: ____

____

7. Mental / Nervous Impairment *(If applicable)*

- ❑ **Class 1** – Patient is able to function under stress and engage in interpersonal relations. ***No limitations***
- ❑ **Class 2** – Patient is able to function in most stress situations and engage in most interpersonal relations. ***Slight limitations***
- ❑ **Class 3** – Patient is able to function in only limited stress situations and engage in only limited interpersonal relations. ***Moderate limitations***
- ❑ **Class 4** – Patient is unable to engage in stress situations or engage in interpersonal relations. ***Marked limitations***
- ❑ **Class 5** – Patient has significant loss of psychological, physiological, personal and social adjustment. Severe limitations

Remarks: ____

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

8. Prognosis	Patient's Job		Any Other Work	
Is patient now totally disabled?	Yes ❑ No ❑		Yes ❑ No ❑	
Do you expect a fundamental or marked change in the future?	Yes ❑ No ❑		Yes ❑ No ❑	
If **YES,** when will patient recover sufficiently to perform duties?	___/___/___	❑ 1 Mo ❑ 1-3 Mos ❑ 3-6 Mos ❑ Never	___/___/___	❑ 1 Mo ❑ 1-3 Mos ❑ 3-6 Mos ❑ Never
If **NO**, please explain:				
Date released to work:	___/___/___		___/___/___	

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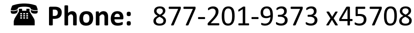
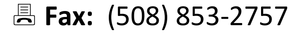
For Claims Customer Service:  **Phone:** 877-201-9373 x45708

For Claims Submission:  **Fax:** (508) 853-2757 **Email:** VBS_Disability@Trustmarkins.com

Section D – Attending Physician Statement *(To be completed by Attending Physician)**(Continued)***

9. Remarks

Physician's Name: (please print): ____

Specialty: ____

Address: ____

Phone: (____) __________________ Fax: (____) ____________________

Physician's Signature: ____ Date Signed: ___/___/___

** Please attach copies of all medical records relating to the claimed condition including treatment notes and test results.*

*** If you require your own Disclosure Authorization to release information, please provide it to the patient.*

Best Doctors®

A Benefit of Trustmark Critical Illness and Critical HealthEvents℠ Insurance

What does peace of mind mean to you?

Trustmark Critical Illness and Critical HealthEvents℠ insurance policies offer strong protection against the financial impact of critical illnesses – but that's not all. If you have one of these policies, you automatically have access to Best Doctors® at no extra cost to you! You and your covered family members can:

- Have the nation's top expert physicians work with you on any medical question or condition you may have.
- Confirm that your diagnosis is correct or get a second opinion
- Ask questions to better understand your treatment options
- Find a highly skilled specialist for any condition
- Know that the treatments you're paying for are right for your situation

Need expert medical advice? It's easy:

1. Log on to bestdoctors.com or call us toll-free at 866-904-0910
2. Discuss your concerns in a comprehensive interview with a medical professional
3. Sign a release so they can access your medical data
4. Get a confidential report and review it with your Best Doctors clinician

You care. We listen.

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Remember, this valuable benefit is FREE for Trustmark Critical Illness and Critical HealthEvents policyholders, so take advantage!

Log on to bestdoctors.com or call toll-free at 866-904-0910

Best Doctors®

A Benefit of Trustmark Critical Illness and Critical HealthEvents℠ Insurance

Best Doctors is **FREE to you** with Trustmark Critical Illness or Critical HealthEvents℠. Log on to **bestdoctors.com** or call toll-free at **866-904-0910**

Five ways Best Doctors can help Trustmark policyholders and covered family members:

1. **FindBestDoc®**
When you need a doctor or specialist, start with the Best Doctors in America® – a database of over 50,000 of the world's top physicians.

2. **Expert Second Opinion**
Confirm your diagnosis or treatment plan. Use Best Doctors for any medical condition – not just a critical illness.

3. **Critical Care Support**
If you're admitted to the hospital with an acute illness, trauma or emergency, Best Doctors immediately gets experts involved and works with your local treatment team. It's like having your own personal medical concierge.

4. **Ask the Expert™**
When you have a question about symptoms, medical conditions or treatment options, an expert takes the time to listen and respond to your concerns.

5. **Medical Records eSummary™**
When you need your medical records, Best Doctors collects and organizes them and creates a Health Alert Summary for you on a USB drive or secure digital file.

Your Best Doctors membership connects you to better care.

A second set of eyes is always beneficial, and most doctors find value in additional information and confirmation of treatments. In fact, a Best Doctors analysis uncovered the following rates of misguided care in medical cases.

Wrong treatments **72%** of the time

Surgery inappropriately recommended in **38%** of surgical cases

Insufficient medical work-ups reported in **31%** of cases

Misinterpretation of pathology or diagnostic tests in **23%** of cases of cases

You care. We listen.

Trustmark Voluntary Benefit Solutions®
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Remember, this valuable benefit is FREE for Trustmark Critical Illness and Critical HealthEvents policyholders, so take advantage! Log on to bestdoctors.com or call toll-free at 866-904-0910

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