

Accident Claim

For Claims Customer Service: **Phone:** 877-201-9373 x45704
For Claims Submission: **Fax:** (508) 853-2867 **Email:** MAWorksite@Trustmarkins.com

This form must be completed by the Attending Physician and the Policyholder and be returned promptly 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.**

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.

Section A – Policyholder Information (To be completed by the Policy Owner) Policy / Certificate #: _____

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____
Street City State Zip Code

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

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

Section B – Claim Information (To be completed by the Policy Owner) Please complete below and attach itemized copies of any related bills – including doctor, emergency room, hospital and motor vehicle incident / accident report. Bills should include diagnosis information from your medical provider.

Name of treated person: _____ DOB: ____/____/____ SSN: _____

Date of Accident: ____/____/____ Date of first treatment for the accident: ____/____/____

Did the accident occur while on the job? Yes No Did injuries occur as a result of a motor vehicle accident? Yes No

If yes to either of the above, please attach a copy of accident or police report

Please describe where the accident occurred and what happened to patient:

Please describe treatment patient received:

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

Name of treated person: _____ Policy / Certificate #: _____

Was patient confined to a hospital?: Yes No

If yes, please provide dates of hospitalization: _____

If hospitalized, please attach a copy of hospital bill(s), showing charges and the # of days you were confined.

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).

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: _____

The statements made by me on this claim are true and complete. I have read and understand the fraud notices contained in this form.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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: _____ Print Name: _____

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

Date signed: ____/____/____

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Section C – Attending Physician Statement *(To be completed by the physician who treated patient for the accident)*

Name of patient: _____ Policy # _____ SSN _____ - _____ - _____

ICD-10 Code: _____ Diagnosis: _____

Was this condition the result of an accident? Yes No If yes, was the accident work related? Yes No

If yes, Date of Accident: ____/____/____ Date of first treatment for the accident: ____/____/____

Was the patient hospital confined? Yes No If yes, dates of hospitalization: _____

During hospitalization, was the patient in intensive care or coronary care unit? Yes No If yes, dates in unit(s): _____

Hospital Name: _____ Hospital Address: _____

If the condition was a fracture, was it an avulsion/chip fracture? Yes No

If the condition was a fracture or dislocation, was it an: Open Injury Closed Injury

If the condition involved laceration(s), what is the length of each laceration? _____

If the condition was a burn, please indicate: 2nd degree: _____ % of Body Surface 3rd degree: _____ % of Body Surface

Did burn require skin grafting? Yes No

As a result of this accident, did patient sustain a concussion? Yes No

If yes, date diagnosis made and the medical imaging procedure performed:

Did the patient suffer from any broken teeth requiring crowns or extractions? Yes No

Did the patient undergo any surgery? Yes No If so, please provide a copy of the operative report.

Is the patient considered to be house confined or unable to perform two or more activities of daily living? Yes No
Activities of daily living mean: Basic human functional abilities for the patient to remain independent. These include: bathing, continence, dressing, eating, toileting or transferring.

Physician's name (please print) _____ Degree _____ Specialty _____

Phone: ____-____-____ Fax: ____-____-____

Address: _____
Street City State Zip Code

Signature _____ Date ____/____/____

May we communicate with you using email: Yes No Email Address: _____

Email Communication: If you choose to communicate with us by email, you should be aware that incoming email is not secure unless it is encrypted. We strongly encourage you to use encrypted email when sending sensitive and/or confidential information. By sending sensitive or confidential email 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 also should be aware that your employer and its agents have access to email communication between you and us.

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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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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 PO 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

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 MAWorksite@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