Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Critical HealthEvents – Caregiver Benefit Claim

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

For purposes of this form, the below definitions pertain:
Home Health Care*:* Personal care including assistance with bathing, dressing and personal hygiene, feeding; dressing changes, monitoring of vital signs, body positioning and basic exercise; medication administration, supervision for safety.
Homemaking*:* Assistance with light housekeeping, shopping and meal preparation, laundry, medication management, bill paying.
Transportation: Assisting individual in order to access needed services outside of home for medical professional services or rehabilitative care.

Person Needing Care:

Last Name _____ First _____ MI ____

Address _____ Apt No._____

City _____ State _____ Zip _____

Birth Date ____/____/____ Soc. Sec. No. _____/_____/_____

Insured Certification/Person Providing Care:

Last Name _____ First _____ MI ____

Address (If Different from above)

Street _____ Apt No._____

City _____ State _____ Zip _____

Telephone No._____-_____-_____ ❑ Home ❑ Cell ❑ Work

E-Mail Address: _____

Birth Date ____/____/____ Soc. Sec. No. _____/_____/_____

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

The above patient requires Caregiving due to: (check all that apply)

❑ Cancer ❑ Coronary Disease ❑ Cerebral Vascular Disease

I hereby certify that I have provided Caregiving services to the above listed individual three or more times per week, individually or in combination, ***for two or more weeks***. I further certify that the person receiving Caregiving services is a spouse, child, parent or sibling. I understand that an Eligible Family Member as defined in the Policy may be verified by Trustmark Insurance. I further verify that I am not receiving compensation for providing such service.

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_____ Date: _____/_____/_____

Print Name _____ **Policy Number**: _____

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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: _____

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HIPAA AUTHORIZATION FORM FOR THE RELEASE OF INFORMATION

Patient's Full Name

Name of Patient's Guardian/Personal Representative (if applicable)

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____
   Name of Medical Provider

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Trustmark Insurance Company

   100 North Parkway, Worcester MA 01605
   Address

   508-853-2757
   Fax Number

3. The specific information that should be disclosed is:

   All medical records and/or documentation related to my physical or mental health.

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION _____

4. I understand that this authorization is voluntary and I may refuse to sign it.
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and may then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying Trustmark Insurance Company in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. The specific purpose/use of the disclosure of this information is for insurance determinations and/or other insurance purposes by Trustmark Insurance Company.
8. I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for healthcare benefits.
9. This authorization is valid for one year from the date this authorization is signed OR until I revoke it, whichever is earlier.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____ _____
Signature of Individual **Date of Individual's Signature**
(The person about whom the information relates)

OR, if applicable –

_____ _____ _____
Signature of Guardian or Personal Representative of Patient | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature

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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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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 Policy Owner: _____ Policy #: _____

Physician Certification

Medical Certification for:_____
(**Name of individual in need of Caregiver services**)

Physicians Name:_____

Business Address:_____

Medical/Surgical Specialty:_____

Telephone:_____ Fax:_____

The above patient requires Caregiving due to: (check all that apply)

❑ **Cancer**

❑ **Coronary Disease**

❑ **Cerebral Vascular Disease**

Date the clinical condition(s) diagnosed: ___/____/_____

Caregiving required for the following (check all that apply):

_____ **Home Health Care**: Personal care including assistance with bathing, dressing and personal hygiene, feeding; dressing changes, monitoring of vital signs, body positioning and basic exercise; medication administration, supervision for safety.

_____ **Homemaking**: Assistance with light housekeeping, shopping and meal preparation, laundry, medication management, bill paying.

_____ **Transportation**: Assisting individual in order to access needed services outside of home for medical professional services or rehabilitative care.

If Yes, as of what date? _____/_____/_____

Have these caregiving needs, individually or in combination, occurred at a minimum frequency of 3 times a week and been continuous for at least two weeks? ❑Y ❑N

Physician Signature_____ Date: _____/_____/_____

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®
PERSONAL. FLEXIBLE. TRUSTED.®

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