

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.

Policy Owner Name: _____

Policy Number(s): _____

Policy Owner's Address: _____

City/State/Zip: _____ **Telephone #:** _____

Name of Third Party Representative: _____

Name of Insured Claimant (if someone other than the Policy Owner): _____

Relationship to Insured Claimant: _____

Address: _____

City/State/Zip: _____ **Telephone #:** _____

Pin# (Must be 4 digits: _____ **Time frame:** _____

Scope of Representation:

- All information (all policy and claim information)
- Only the following information*:

*Restrictions may include only information with regard to a specific claim, a specific time period, or a restriction on certain types of information (such as not sharing medical or health information with this representative).

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 CustomerCare@trustmarksolutions.com. Trustmark Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for the time frame requested above. I may request a copy of this authorization and a copy is as valid as the original.

Signature of Policy Owner

Signature of Insured Claimant (If other than the Policy Owner)

Printed Name

Printed Name

Date

Date

Submission Instructions:

Upon completion of this form return to Trustmark Insurance.

Fax:

Fax Form To: (847) 615 – 4943

Mail:

Mail completed Form to: Trustmark Customer Care
400 Field Drive
Lake Forest, IL 60045
ATTN: Customer Care / Promise Team

Email:

Email Form To: CustomerCare@trustmarksolutions.com