We have recently received information that indicates you wish to file a claim with our company under the above captioned policy. As such, we have enclosed a claim form for your completion to start the process.

This form consists of 4 sections. Each section needs to be completed in full as indicated below, and returned to us to consider the claim. They include:

1) The **Claimant's Statement:** which outlines your description of the events related to the claim. Be sure to sign and date in the section provided.
2) The **Disclosure Authorization:** which allows us to obtain information to consider the claim.
3) The **Attending Physician's Statement:** which should be completed by the physician who is treating you for your condition. It is important to have the dates of treatment and you physician's signature and date on this portion of the form.
4) The **Employer Statement:** which should be completed by your employer to provide verification of the occupation, earnings and work information prior to the start of the disability.

Once we receive the claim form, an acknowledgement letter will be sent to you confirming that we have received all or part of your claim form, and providing you with the name of the Claim Representative who will be assigned to the case. Your Claim Representative will be in contact with you shortly thereafter to outline the policy provisions, explain how the claim process will work, and advise you of any additional information which may be required to consider the claim.

It is very important for you to continue to make your premium payments while we determine your eligibility for benefits. If you have been paying your premiums through payroll deductions, and you're no longer receiving a paycheck, please contact Policy Owner Services at 1-800-918-8877 to arrange your billing. If your premiums are not paid current, we may reduce any potential benefit payment by the amount of premium owed.

Please contact us at 1-877-201-9373 if you have any questions.

Sincerely,

Trustmark Insurance Company
Disability Benefits

Please mail completed claim form to: **Trustmark Insurance, 100 North Parkway, Suite 200, Worcester, MA 01605**
Phone: 877-201-9373, Fax: 508-853-2757

Trustmark INSURANCE COMPANY

IMPORTANT: PLEASE SIGN AND DATE AUTHORIZATION ON THE FINAL PAGE OF THIS FORM

CLAIMANT'S STATEMENT *To be completed by Insured* **Policy #**

Last Name ____________________________ First ___________________ MI ____ Soc. Sec. No. __________________ Birth Date ____/____/____ Gender: ❑ M ❑ F

Address ____ Apt No._______________City _____________________________ State ______ Zip ____________

Telephone No.__________________Spouse's Name ________________________________ Dependents (please list & provide ages) __________________________________

Employer Name & Address: ____ Telephone Number: _________________________

Were you employed at the time of your impairment? Yes ❑ No ❑ Full-Time? Yes ❑ No ❑ Annual net income prior to disability? $_____________________

❑ Accident ❑ Sickness Date Occurred ____/____/____

Describe where & how it occurred & what illness/injury resulted: ____

Have you had a similar illness/injury? ❑ Yes ❑ No If yes, date(s) ____________________________

Date of first treatment by a physician for this condition ____/____/____ Work Related Yes ❑ No ❑

Name & Address of physician or hospital who first treated you for this condition: ____

If hospitalized, provide dates and name of hospital: ____

I was unable to work from: _____/_____/_____ To _____/_____/_____ I returned to work in a limited capacity from ____/____/____ To _____/_____/_____

List any Physicians, Surgeons & Health Care Providers who attended to you and/or Pharmacies you have utilized during the past 3 years. Attach additional sheets if needed.

Name: ______________________________ **Address**___________________________**Phone#**_____________________**Reason**_______________________**Dates**_________

Name: ______________________________ **Address**___________________________**Phone#**_____________________**Reason**_______________________**Dates**_________

Please indicate any benefits that you are eligible to receive:

Source	Amount	Date Applied	Payments Began	Payments End	Source	Amount	Date Applied	Payments Began	Payments End
State Disability	$________	____/____/____	____/____/____	____/____/____	Soc. Sec.	$_______	____/____/____	____/____/____	____/____/____
Workers' Comp	$________	____/____/____	____/____/____	____/____/____	Unemployment	$________	____/____/____	____/____/____	____/____/____
Retmnt/Pension	$________	____/____/____	____/____/____	____/____/____					

If you have other disability insurance coverage please complete the information below:

Company Name______________________________Policy #________________Benefit Amount/month $____________Effective date of Coverage ___/___/_____

Company Name______________________________Policy #________________Benefit Amount/month $____________Effective date of Coverage ___/___/_____

Occupation

Occupational Title(s) ____ # of hours worked in a normal week _________ Nature of employer's business __________________

Supervisor's Name: ____ Years with employer _______ Years in occupation _______ If retired, date of retirement ___/___/___

Please provide a description of your occupation to include your important duties (attach separate sheet if necessary)

____

____

Please explain how your condition has interfered with the performance of your job. Please be specific.

____

____

Indicate the frequency of the following activities (check the appropriate boxes)

	Performed in job		
Activity	Occasionally (0-33%)	Frequently (34-66%)	Constantly (67-100%)
Sitting			
Standing			
Walking			
Driving			

	Performed in job		
Activity	Occasionally (0-33%)	Frequently (34-66%)	Constantly (67-100%)
Lifting			
Carrying			
Pulling			
Pushing			

Lifting: Usual number of pounds _________ Maximum number of pounds _________ Carrying: Usual number of pounds ________ Maximum number of pounds _________

Please be sure all portions of claim form are completed

EMPLOYER STATEMENT *To Be Completed By Employer* **Please Attach Job Description**

Employee's name ______________________________________ Hire Date _____/_____/_____ Birth Date _____/_____/_____ Job Title ___________________________

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

Reason not working: ❑ Sickness ❑ Injury ❑ Retired ❑ Resigned ❑ Granted LOA ❑ Dismissed ❑ Vacation ❑ Laid Off ❑ Other ____________________________

Is the present condition the result of an accident or injury on the job? ❑ Yes ❑ No If yes, date of accident _____/_____/_____

Has a Workers Compensation Claim Been Made ❑ Yes ❑ No Job Classification: ❑ Heavy Labor ❑ Moderate Labor ❑ Light Labor ❑ Sedentary/Clerical Labor

Hours worked during the week _________ Circle regular work schedule S M T W T F S

Date employee returned to Regular duties: F/T ____/____/____ P/T ____/____/____ Light duties: F/T ____/____/____ P/T _____/_____/_____

Employee's gross monthly earnings preceding disability Base: $__________ O/T: $ __________ Is salary based on 12 months? ❑Yes ❑ No _____ mos.

Was employee absent from work for any reason, other than vacation or pregnancy, during the period of: ______________ thru ________________ ☐ Yes ☐ No

(Please note the above dates will not be the same as the current disability)

If Yes: Date:____ Cause: ____

Date: ____ Cause: ____

Employer ____ Telephone _________________________________ Fax ______________________________

Address____

Signature ____ Title____ Date____________________________

ATTENDING PHYSICIAN STATEMENT **The patient is responsible for the completion of this form by his/her physician without expense to this company**

Name of patient ____Date of birth _____/_____/_____Date symptoms first appeared or accident happened _____/_____/_____

Date patient ceased work because of impairment _____/_____/_____Date of first treatment _____/_____/_____ Dates of subsequent treatments___________________________

CHECK YOUR RESPONSES: Is this condition due to ❑ an Accident ❑ a Sickness? Is the accident or sickness related to the patient's employment? ❑ Yes ❑ No

Is condition due to pregnancy ❑ Yes ❑ No Est. Date of Delivery: _____/_____/_____ Delivery Type: ❑ Vaginal ❑ C-Section

Was patient referred to you by another physician? ❑ Yes ❑ No If yes, please list name, address, and specialty____

____

Primary diagnosis____Subjective symptoms____

Objective findings (including the results of X-rays, EKG's, laboratory data, and any clinical findings)____

Has patient been hospital confined? ❑ Yes ❑ No From _____/_____/_____ To _____/_____/_____ If yes, Hospital name____

Do you consider the patient to be completely unable to work in his/her occupation? ❑Yes ❑ No If yes, please provide dates From _____/_____/_____ To _____/_____/_____

If still completely unable to work, when do you expect patient will be able to return to his/her work duties?❑ 1 – 3 mo. ❑ 3 – 6 mo. ❑ 6 – 12 mo. ❑ More than 12 mo.

If patient is able to do some work, for what period will patient be restricted from his normal duties? From _____/_____/_____ To _____/_____/_____

What are patient's current limitations?____

Is patient competent to endorse checks and direct the use of proceeds thereof? ❑ Yes ❑ No

Have you completed claim forms regarding this patient for other insurance carriers? ❑ Yes ❑ No If Yes, Name of insurance company:______________________________

Physician's name (please print)____ Degree _____________ Specialty ____________________ Phone______________________

Address____

Signature ____ Date ______/_____/______ Fax # ____

Please be sure all portions of claim form are completed

Fraud Statement for Alaska 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 Arizona Residents: For your protection Arizona law requires the following statement to appear 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 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 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 Kansas, and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

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 Arkansas, Louisiana, 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 Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD STATEMENT FOR DISTRICT OF COLUMBIA, MAINE, VERMONT, TENNESSEE AND VIRGINIA RESIDENTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Fraud Statement for New Hampshire Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided under RSA638:20.

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.

FRAUD STATEMENT FOR NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

Fraud Statement for 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 Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Warning for Delaware, Idaho, Indiana, and Oklahoma, As Well as for the Residents of All States Not Specifically Listed WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

Information Pertaining To Policy Premiums

In order to prevent the loss of your policies, it is necessary to have any premiums due paid appropriately. As a service to you, we can withhold premiums from your benefits for as long as you are receiving benefit payments if you agree. Please denote below which you would prefer regarding your premium payments:

☐ **Yes,** please maintain my Trustmark policy(s) in force by withholding premiums while I am receiving benefit payments.

☐ **No**, I will make the payments myself , as needed to maintain my policy(s).

Please review and sign both sections below.

DISCLOSURE AUTHORIZATION

Insured's name (Please Print): ____

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 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, 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. This Authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below.

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.

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 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.

Residents of NY – 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: ____________________________ Insured's Signature: __________________________________

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

If I receive disability income 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 disability payments in order to recover any overpayment balance that is not returned.

I hereby declare that all statements given herein in the preceding pages are true and complete to the best of my knowledge and belief.

Date: _________________________ Signed: _______________________________________

Print name: __________________ _______________________________________

Relationship, if other than insured