Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Accident Claim Form

100 North Parkway, Suite 200, Worcester, MA 01605 ☎ Phone: 877-201-9373 🖷 Fax: 508-853-2867 **www.trustmarksolutions.com**

***** IMPORTANT NOTICE *** In order for us to consider any benefits, you must attach any/all copies of Hospital Admission & Discharge Summary, Operative Reports, Emergency Room Discharge Summary, or Inpatient / Outpatient Bills / Invoices. All bills should include diagnosis, services rendered, and actual charges for the service(s).**

- ⇨ **Section A & B -** Complete both sections, sign and return to us for consideration of benefits. All questions must be answered in full. **Incomplete or illegible answers may result in delay of benefit consideration**. Please keep a copy of all parts of this form and any attachments for your records.
- ⇨ **Section C** – Have the physician who treated you complete this section, sign and return to us.
- ⇨ **State Required Fraud Language:** Attached for your information
- ⇨ **Disclosure Authorization:** You, the policy owner, must sign & date this form and return back to us. Provide a copy of the signed and dated authorization to your attending physician.
- ⇨ **Insured Statement of Claim – Communication (Optional):** Complete only if you would like us to communicate with you by email **OR** if you would like us to discuss, release or provide information to others you designate regarding your claim.

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: _____

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 copy of accident or policy report

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

_____

_____

Please describe treatment patient received:

_____

_____

Was patient confined to a hospital?: ❑ Yes ❑ No If yes, please provide dates of hospitalization: _____

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

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.

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-9 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 used: _____

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.

Activities of daily living mean: Basic human functional abilities for the patient to remain independent. These include: bathing, continence, dressing, eating, toileting or transferring.

Is the patient considered to be house confined or unable to perform two or more activities of daily living? ❑ Yes ❑ No

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: _____

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State Required Fraud Warnings

Fraud Statement for Alaska and 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 AZ 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 CA 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 CO 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 FL 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 KY 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, New Mexico, 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 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 MN 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 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 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 STATEMENT FOR DISTRICT OF COLUMBIA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON 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 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.

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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 term of coverage of the policy or up to 12 months from the date shown below, 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 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.

RESIDENTS OF ME: 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.

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

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

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Insured Statement of Claim - Communication

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 can communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with you electronically? ☐ Yes ☐ No

Which would you prefer? ☐ Email Please provide email address: _____

☐ Text Messages Please provide cell phone #: (_____) - _____ - _____

Please provide your service provider: ☐ AT & T ☐ Verizon ☐ T-Mobile ☐ Sprint ☐ Virgin Mobile ☐ US Cellular ☐ Nextel ☐ Boost ☐ Alltel

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 in writing.

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 or bulk email folder.
You can choose to stop email communication at any time by revoking this authorization. If you no longer wish to communicate via email we will correspond with you via US mail. If you require copies of any communication sent to you by email in paper form, please contact us. There is no cost to you to obtain copies of email communication in paper format.

THIRD PARTY COMMUNICATION

Please complete this section if you would like us to discuss, release or provide information to a family member, friend or other third party concerning your claim, benefits, policy, premium or condition.

I hereby authorize Trustmark Insurance, its subsidiaries and duly authorized representatives to release information pertaining to my claim for benefits with the person or persons listed below:

My Spouse or Partner's Name: _____

My Family Member(s): _____ _____
Name and Relationship *Name and Relationship*

Other Third Party: _____ My Agent: ☐ Yes ☐ No
Name and Relationship

I authorize Trustmark to leave messages on voicemail or answering devices ☐ Yes ☐ No

I agree that information about my claim that can be released 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 redisclosure and might not be protected by certain federal regulations governing the privacy of health information relative to my condition.

AUTHORIZATION

I may revoke or update this authorization in writing at any time or by email to vbs_disability@trustmarkinsurance.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 two (2) years. 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***