Trustmark
benefits beyond benefits

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Claim Submission Instructions and Supporting Documentation

Please be sure to review the requirements noted below for claim submission and ensure your submission is complete and to avoid any delays on your claim.

Please keep a copy of all parts of this form and any supporting documentation for your records.

Please note: If your certificate # begins with "T" or "C", please do not use this form to file your claim. Please call (800) 554-1640 to obtain the appropriate claim form.

Supporting Documentation

Required: Be sure to include any information, that you feel will assist us in understanding your claim. Addadditional pages if you need more room to respond to a question.

- Provide a signed Healthcare or Durable Power of Attorney document, if applicable.
- If receiving professional care, provide a current copy of nursing home, assisted living or home health care agency license.
- Provide any testing or neuropsychological evaluations, if completed.
- During the initial claim filing process, we may ask for additional information from you and/or yourprovider(s) to learn more about your condition and care needs.

Required: Be sure to fully complete the following required portions of the claim form. Incomplete or illegible answers may result in delay of benefits.

The following information must be supplied:

- **A fully completed claim form- Section A, B, & C –** *To be completed by Certificate Owner Patient).* Complete these sections in full and return for review of benefits.
- **Disclosure Authorization -** *To be completed by (Patient) (or Certificate Owner, if Patient is under 18 orlegally incapacitated.)* Be sure to sign and date this section of the form, including DOB & last 4 digits of SSN where indicated.
- **Claim Submission Signature** – *To be completed by Certificate Owner (Patient).* Be sure to sign and date this sectionof the form.
- **Attending Physician Statement** – *To be completed by the Physician primarily responsible for the patient'scare.* Please be sure that all dates of treatment are indicated in this section and that the physician signs and dates the form.
- **Third Party Communication Authorization** – *To be completed by Certificate Owner& Patient.* Complete if youwould like to authorize Trustmark to release information on your claim(s) to a third party such as a spouse,friend or agent.

Informational:

- **E-Sign Disclosure and Consent Notice** – *This section of the claim form is not required but completing it will provide better and faster communication with you or anyone you designate. Complete if you would like claim communication by text or email, including text alerts for payments released. If not completed, please note default communication will be written and sent via USPS.*
- **State Required Fraud Language** – These sections of the claim form provide important information about the laws in each state.

Chronic Care Initial Claim Form

Trustmark
benefits beyond benefits

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Insured's Statement of Loss

Certificate No:_____

*To Be Completed Only By Certificate Holder or Authorized Representative – **Please Print***

A. Contact Information

1. Insured Name:_____Date of Birth:_____SSN:_____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ Cell: _____

2. Contact Person: (If unable to reach. Please be sure to complete Third Party Authorization to allow contact)

   Name: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ Relationship: _____

3. Do you have a Power of Attorney, Conservator or Guardian or other person that can legally represent you?
   Y ☐ N ☐ If yes, please note name and contact info below:

   Name:_____

   Address: _____

   City:_____State:_____Zip:_____Phone: _____

Please submit a copy of the documentation giving this person legal authority.

B. Information About the Condition(s) Causing Your Impairment

1. What is your medical condition? _____
2. What are your symptoms? _____
3. When did you first receive assistance due to difficulties with activities of daily living or severe cognitive impairment (mm/dd/yy)?_____
4. Please specify your treatment history/physicians/rehabilitation during the past year below, starting with the most recent treatment. (Please attach additional pages if needed)

   Name of Physician: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ Condition(s) Treated: _____

   Name of Physician: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ Condition(s) treated: _____

Trustmark
benefits beyond benefits

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

C. Information about Care

Do you need assistance with the following (please check all that apply):

☐ Bathing ☐ Continence ☐ Dressing ☐ Eating ☐ Toileting ☑ Transferring

☐ Severe Cognitive Impairment: ☐ Yes ☐ No

Type of Service Receiving

Receiving This Service?	**Type of Agency/ Facility**		**Phone #**
☐ Yes	Professional Caregiving	Name and address of agency/facility	
☐ Yes	Family Caregiving	Name and address of family caregiver	

If other please specify:

If yes to any of above, please provide first date you began receiving care:

D. Frequency of Care

How often are you receiving care?

☐ Daily? How many hours per day? _____

☐ Weekly? How many days per week? _____

☐ Monthly? How many days per month?_____

E. Amount of Benefit – Please identify which option you are requesting:

☐ If the periodic benefit is selected, We will pay the benefit for each period the Insured meets conditions for payment up to Certificate limitations. Once this option is selected, You may not later elect the One-time Lump Sum Payment Option. The remaining face amount and remaining death benefit will further reduce each time a periodic payment is made.

☐ If the One-time Lump Sum Payment Option is selected, no additional payments will be made for Chronic Care Accelerated Death Benefits. Any Extension of Chronic Care Accelerated Death Benefits (if included in your Certificate) will no longer be available.

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

E-Sign Disclosure and Consent Notice

This E-Sign Disclosure and Consent Notice ("Notice") applies to all communications, as defined below, for services provided by Trustmark Companies and our affiliates ("Trustmark" or "We"). Under this Notice, communications you receive in electronic form from us will be considered "in writing."

By using Trustmark electronic and online services ("Electronic Services"), you acknowledge that your electronic signature is legally binding and shall be treated as a valid signature for all purposes.

In addition, by using Trustmark Electronic Services you consent to the entirety of this Notice and affirm that you have access to the hardware and software requirements identified below. You must review and accept the terms of these services. If you choose not to consent to this Notice or you withdraw your consent, you will be restricted from using Electronic Services.

PREFERRED METHOD OF COMMUNICATION

☐ Text Messages and Email - Please provide cell phone #: _____

☐ Email Only - Please confirm email address:_____@ _____

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 lackof 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.

You 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. Thisconsent shall remain in effect unless revoked by notifying Trustmark.

COVERED COMMUNICATIONS

Includes, but is not limited to disclosures or communications we provide to you regarding our services such as: (i) claim submissions, third party authorizations, overpayment authorizations, fraud notices, terms and conditions, privacy statements or notices and any changes thereto; and (ii) customer service communications (such as claims of error communications) ("Communications").

METHODS OF PROVIDING COMMUNICATIONS

We may provide Communications to you by email or by making them accessible on the Trustmark websites, mobile applications, or mobile websites (including via "hyperlinks" provided online and in e-mails). Communications will be provided online and viewable using browser software or PDF files.

HARDWARE AND SOFTWARE REQUIREMENTS

To access and retain electronic Communications, you must have:

- A valid email address;
- A computer, mobile, tablet or similar device with internet access and current browser software and computer software that is capable of receiving, accessing, displaying, and either printing or storing Communications received from us in electronic form;
- Sufficient storage space to save Communications (whether presented online, in e-mails or PDF) or the ability to print Communications.

We may request that you respond to an email to demonstrate you are able to receive these Communications.

Chronic Care Initial Claim Form

For Claims Customer Service:	**Phone:** 866-813-7192		
For Claims Submission:	**Fax:** 508-718-2411	**Email:** GroupLifeClaimsVB@trustmarkbenefits.com	
	Mail: P.O. Box 2906 Clinton, IA 52733		

HOW TO WITHDRAW YOUR CONSENT
You may withdraw your consent to receive Communications under this Notice by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733." Your withdrawal of consent will cancel your agreement to receive electronic Communications, and therefore, your ability to use our Electronic Services.

REQUESTING PAPER COPIES OF ELECTRONIC COMMUNICATIONS
You may request a paper copy of any Communications; we will mail you a copy via U.S. Mail. To request a paper copy, contact us by writing to "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733." Please provide your current mailing address so we can process this request. Trustmark may charge you a reasonable fee for this service.

UPDATING YOUR CONTACT INFORMATION
It is your responsibility to keep your primary email address current so that Trustmark can communicate with you electronically. You understand and agree that if Trustmark sends you a Communication but you do not receive it because your primary email address on file is incorrect, out of date, blocked by your service provider, or you are otherwise unable to receive electronic Communications, Trustmark will be deemed to have provided the Communication to you; however, we may deem your account inactive. You may not be able to transact using our Online Services until we receive a valid, working primary email address from you.
If you use a spam filter or similar software that blocks or re-routes emails from senders not listed in your email address book, we recommend that you add Trustmark to your email address book so that you can receive Communications by e-mail.
You can update your primary email address or other information by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733.

FEDERAL LAW
You acknowledge and agree that your consent to electronic Communications is being provided in connection with a transaction affecting interstate commerce that is subject to the federal Electronic Signatures in Global and National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct business with you by electronic means.

TERMINATION/ CHANGES
We reserve the right, in our sole discretion, to discontinue the provision of your Communications, or to terminate or change the terms and conditions on which we provide Communications. We will provide you with notice of any such termination or change as required by law.

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.

_____ _____
Beneficiary Signature ***Date Signed***

_____
Printed Name

Address: _____
Street City State Zip Code

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

State Required Fraud Language

Fraud Statement for the states of Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma, as well as for 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 the state of Arizona: 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 the states of Arkansas, Louisiana, New Mexico, Rhode Island, Texas and West Virginia: 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 the state of California: 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 the state of Colorado: 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 the District of Columbia, and the states of Maine, Tennessee, Virginia and Washington: 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 the state of Florida: 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 the state of Kentucky: 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 the state of Maryland: 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 the state of New Hampshire: 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 in RSA 638:20.

Fraud Statement for the state of 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 the state of New York: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In New York, civil penalty shall not exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Statement for the state of Oregon: 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 the state of Pennsylvania: 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.

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Disclosure Authorization

Insured's name (Patient) (*Please Print***):**_____ **Last 4 of SSN#** _____

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 certificate 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 certificate 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 certificate claim benefits with respect to me. A photocopy of this Authorization is as valid as the original and I (or my authorized representative) may request a copy. I understand that 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 certificate. I understand that there is a possibility of redisclosure of information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that I may request a record of redisclosure of any information.

Patient Signature (or Certificate Owner, if Patient is under 18):_____

Signed by: ☐ Certificate Owner ☐ Patient Date Signed:_____ Patient's Date of Birth: _____

Relationship, if other than insured: _____

Trustmark
benefits beyond benefits

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

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 any certificate and/or claim for benefits under your certificate. Note: Certificate Owner and Claimant (if appropriate) must give permission for disclosure of their information to each other, if applicable.

Certificate Owner Name:_____

Patient Name: _____

Certificate Number(s): _____

Name & Relationship of Third Party Representative: _____

□ All information (all certificate and claim information)

□ Only the following information*: _____

Name & Relationship of Third Party Representative: _____

□ All information (all certificate and claim information)

□ Only the following information*: _____

My Agent: (Name of Agent) _____

□ All information (all certificate and claim information)

□ Only the following information*: _____

My Employer: (Name of Agent) _____

□ All information (all certificate 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 certificate and/or 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 address noted above. I understand that this authorization is valid until my revocation or until I complete a new authorization. Any new authorization will effectively revoke this authorization and replace it.

_____ _____

Signature of Certificate Owner
Or Certificate Owner's Personal Representative's Signature

Signature of Patient (If someone other than the Certificate Owner)

_____ _____

Printed Name

Printed Name

_____ _____

Date

Date

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Claim Submission Signature

I declare that all of the above statements on this claim form and attached documentation are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices contained in this form.

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.

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

_____ _____
Printed Name of Patient **or** authorized/legal representative Date

_____ (_____)_____
Signature of authorized/legal representative Phone

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement (Pg. 1 of 3)

*To Be Completed Only By Attending Physician – **Please Print*** ***Certificate No:_____***

A. Patient Information

1. Name of Patient:_____DOB: _____

B. Medical Information

1. What is the primary diagnosis/medical reason that may impact your patient's functional capacity and require caregiving services to perform ADLs?

   _____

   _____

   _____

2. What date did symptoms first appear (mm/dd/yy)? _____

3. Date your patient first consulted with you for this condition (mm/dd/yy)? _____

4. Date of last office visit (mm/dd/yy): _____

5. Have you recommended any type of health care services or substantial hands-on care for this patient within the last12 months (e.g. home care, adult day care, nursing home)? Yes ☐ No ☐
   If yes, date of recommendation (mm/dd/yy): _____
   Services recommended:

   _____

   _____

   _____

   Did patient comply? Yes ☐ No ☐

In the past 36 months did the patient smoke or use tobacco products: ☐ Yes ☐ No

Trustmark
benefits beyond benefits

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement *(Continued Pg. 2 of 3)*

C. Functional Capacity

In general, an insured's eligibility for Chronic Care Accelerated Death benefits is based on the loss of independence with Activities of Daily Living (ADLs) and/or the presence of severe cognitive impairment requiring another person's assistance/supervision. Assistance with an ADL can mean either stand-by or hands-on assistance by another individual.

Please provide your opinion below as to what ADL loss, if any, your patient has experienced and indicate whenthis loss began and how long you anticipate this loss will last. We have provided general definitions of ADLs in the beginning of this packet for your reference.

Rating Scale:	**0** = Individual **can perform the entire activity** with or without aid of equipment.
	1 = Individual participates in process but **requires supervision to complete the task**.
	2 = Individual is unable to participate in the activity without hands-on assistance from another individual.
	3 = Individual is **mostly or completely dependent** on someone else for the task completion.

ADL	When did lossbegin? (mm/dd/yy)	Based on the date on which this form has been completed, when do you anticipate improvement?	Rating Scale
Bathing ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Dressing ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Continence ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Toileting ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Eating ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Transferring ☐ No Loss	_____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of _____(Date)	☐ 0 ☐ 1 ☐ 2 ☐ 3

Is your opinion based on: ☐ Clinical Observation ☐ Functional Evaluation/Testing ☐ Patient/Family Report?

Trustmark
benefits beyond benefits

Chronic Care Initial Claim Form

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement *(Continued Pg. 3 of 3)*

D. Cognitive Capacity

1. Does your patient have a severe cognitive impairment? Yes ☐ No ☐

If yes please complete following questions:

2. Does your patient have a severe cognitive impairment to the degree that it puts him/her at risk for health and safety? Yes ☐ No ☐

If yes, when did the severe cognitive impairment begin to impair your patient to the degree that it put them at risk for health and safety? (mm/dd/yy) _____

3. Is your patient currently receiving direct supervision to protect themselves or others due to severe cognitive impairment? Yes ☐ No ☐

If yes, How many hours per day?_____How many days a week? _____

When did the direct supervision begin (mm/dd/yy)? _____

Who provides the direct supervision? _____

4. What is the cognitively impairing diagnosis?
☐Delirium ☐Psychiatric ☐Dementia – with specific type_____ ☐Other _____

5. When was your patient first seen for cognitive issues and by whom? (mm/dd/yy) _____

_____

_____

6. Has any cognitive testing been completed? Yes ☐ No ☐ **If yes, please attach testing with this completed form**

E. Signature of Attending Physician

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.

The above statements are true and complete to the best of my knowledge and belief.

Physician's Name: (please print):_____

Specialty:_____

Address: _____

Phone: (____)_____ Fax: (____) _____

Are you related to this patient? Yes ☐ No ☐ If yes, what is relationship? _____

Signature:_____ Date Signed: _____