Group Hospital Indemnity Claim Form

For Claims Customer Service: ☎ **Phone:** (866)-813-7192
For Claims Submission: 🖷 **Fax:** (866) 680-0401 ✉ **Email:** GroupHospitalClaimsVB@trustmarkbenefits.com

Instructions for Claim Submission

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

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

This is not a guarantee of payment. Benefits will be determined based on certificate provisions. The certificate owner is responsible for completion of all portions of this form without expense to Trustmark Companies.

Supporting Documentation

Required: Be sure to include the required supporting documentation noted in each section of the claim form. Other proof of treatment may also be needed.

Claim Form

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

- **Section A & B** – To be completed by the certificate owner.
- **Section C** – To be completed by the certificate owner **only if** claiming Waiver of Premium Due to Disability.
- **Section D** – To be completed by treating physician **only if** claiming Waiver of Premium Due to Disability
- **Disclosure Authorization** – To be completed by the patient unless the patient is a minor or legally 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 the certificate owner. Be sure to sign and date this section of the form.

Optional: These sections of the claim form are not required, but completing them will provide better and faster communication with you or anyone you designate

- **E-Sign Disclosure and Consent Notice** – To be completed by the certificate owner. Complete if you would like claim communication by text or email, including text alerts for any payments released.
- **Third Party Communication Authorization** – To be completed by the certificate owner and the patient unless the patient is a minor or legally incapacitated Complete if you would like to authorize Trustmark to released information on your claim(s) to a third party such as a spouse, friend or agent.

Informational: These sections of the claim form provide important information about your rights and the laws in each state.

- **State Required Fraud Notices** - Attached for your information.

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Section A – Certificate Owner Information *(To be completed by the Certificate Owner)*

Certificate #: _____ SSN #(last 4 digits): _____

Certificate Owner Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Phone #_____ ❑ Home ❑ Cell ❑ Work E-Mail Address: _____

Employer's Name: _____ Employee of Trustmark? ❑ Yes ❑ No

Section B – Claim Information *(To be completed by the Certificate Owner)*

Name of patient: _____ DOB: _____ SSN # (last 4 digits):_____

Relationship to Certificate owner: ❑ Certificate owner ❑ Spouse/Domestic Partner ❑ Son/Daughter
❑ Other _____

Reason for Claim: ❑ Accident ❑ Sickness ❑ Childbirth

ICD10 Code (if known): _____ Diagnosis: _____

If claim is due to an accident, please provide a description of the accident including date of accident, where it occurred and what happened to the patient:

Is claim due to injuries sustained in a Motor Vehicle Accident (MVA)? ❑ Yes ❑ No
(If Yes, a copy of MVA report is required)

Did the accident occur on the job? ❑ Yes ❑ No *(If Yes, a copy of work incident report is required)*

Date of **first** diagnosis for condition claimed: _____

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Was patient confined in a hospital as the result of a covered accident or covered sickness? ❑ Yes ❑ No

Total number of days confined to the hospital? ___________

Note: Room & Board, ICU and Hospital Step Down charges must be incurred. Confinement in a rehab or mental health or substance use unit may not be a covered benefit. Observation Unit requires admission of at least 20 hrs.

Proof of Admission and discharge dates, reason for confinement, hospital name and address and room type is required.

Please provide the following information pertaining to first date of hospital confinement:

Date	Type of Room	Comments
	❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit	
	❑ Observation Unit Admission Time:	Discharge Time:

Please provide the following information for all additional dates of confinement:

Date	Type of Room	Date	Type of Room
	❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit		❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit
	❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit		❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit
	❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit		❑ Regular ❑ ICU ❑ Hospital Step Down ❑ Rehab Unit ❑ Mental Health or Substance Use Unit
	❑ Observation Unit Admission Time:		Discharge Time:

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Please list all hospitals where dates of admission confinement listed on prior page of claim form occurred			
Name of Hospital	**Address**	**Indicate if Hospital is more than 50 miles from patient's primary residence?**	**If Yes, was patient accompanied by an adult companion who required overnight lodging?**
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No

Note: *If you answered yes to the lodging question above and your certificate contains benefits for lodging, please provide proof for number of nights.*

Surgical Benefit Rider Some select certificates include coverage when a Covered Person undergoes Surgery as a result of a Covered Sickness or Accident. If your certificate includes this coverage, please complete below if you are claiming this benefit. (*Copy of operative report is required*)

Date of Surgery: ____-____-____

Name of Surgery Performed: _____

Type of Surgery: ❑ Inpatient ❑ Outpatient

Name of Facility where surgery was performed: _____

Address of Facility: _____

Was anesthesia required? ❑ Yes ❑ No If Yes, Describe:

❑ General including Epidural ❑ Local, Conscious Sedation

Imaging Benefit Rider Some select certificates include coverage for laboratory tests or diagnostic imaging tests the below when received to determine diagnosis or monitor response to treatment. If your certificate includes this coverage, please complete below if you are claiming this benefit:

(Proof of test such as copies of bills, invoices, explanation of benefits, treatment notes or discharge statements is required)

Service Category	**Name of Test**	**Test Date**
❑ Laboratory Test		
❑ Laboratory Test		
❑ Laboratory Test		
❑ Imaging Test		
❑ Imaging Test		
❑ Imaging Test		

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Immediate Care Benefit Rider Some select certificates include coverage if you require treatment in an Emergency Room, Walk-In Clinic, Doctor's Office or Telemedicine Visit or if you require transportation by ambulance. If your certificate includes this coverage, please complete below if you are claiming this benefit.

(Proof of treatment or transport is required)

Please list all dates & location of treatment(s) for this condition received:

Date	Location
	❑ Emergency Room (ER) ❑ Walk-In Clinic ❑ Doctor's Office ❑ Telemedicine
	❑ Emergency Room (ER) ❑ Walk-In Clinic ❑ Doctor's Office ❑ Telemedicine
	❑ Emergency Room (ER) ❑ Walk-In Clinic ❑ Doctor's Office ❑ Telemedicine

Please provide the name and address of the facilities where treatment was received.

Please list all dates of ambulance rides taken for this condition:

Date	Type of Ambulance
	❑ Ground ❑ Water ❑ Air
	❑ Ground ❑ Water ❑ Air
	❑ Ground ❑ Water ❑ Air

Please provide the name and address for the ambulance service:

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Rehabilitation Services Rider Some select certificates include coverage when a Covered Person receives outpatient rehabilitation, mental health or substance use services. If your certificate includes this coverage, please complete below if you are claiming this benefit.

(Proof of treatment such as medical records, UB-04 insurance billing form, HCFA or CMS 1500 billing form or therapy attendance records are required. Any documents must include date of treatment, who received treatment, where treatment was received and who provided therapy.)

Please complete the following information for all dates of outpatient rehabilitation:

Treatment Date	Type of Treatment	Name & Address of Facility
	❑ PT (Physical Therapy) ❑Mental Health Rehab ❑ Speech Therapy ❑Substance Use Rehab ❑ OT (Occupational Therapy)	
	❑ PT (Physical Therapy) ❑Mental Health Rehab ❑ Speech Therapy ❑Substance Use Rehab ❑ OT (Occupational Therapy)	
	❑ PT (Physical Therapy) ❑Mental Health Rehab ❑ Speech Therapy ❑Substance Use Rehab ❑ OT (Occupational Therapy)	

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Section C - Waiver of Premium for Disability – Certificate Owner Statement *(To be completed by Certificate Owner)*
Some select certificates provide for waiver of premium for disability. Please complete this page only if you are claiming this benefit.

Claim Information

Name of patient: _____ DOB: _____ SSN # (last 4 digits):_____

Address: _____
Street City State Zip Code

Phone #_____ ❑ Home ❑ Cell ❑ Work E-Mail Address: _____

What is the cause of your disability?	What is your occupation?
Date Disability Began? (Date = MM/DD/YYYY)	Return to work date (if known)? (Date = MM/DD/YYYY)
Name of Physician:	Name of Employer:
Address (Street)	Address (Street)
City State ZIP Code	City State ZIP Code
Phone Number Fax Number	Phone Number Fax Number

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Section D - Waiver of Premium for Disability – Physician's Statement *(To be completed by Physician)*
Some select certificates provide for waiver of premium for disability. Please have your physician complete this page only if you are claiming this benefit.

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.

Name of patient: _____ DOB: _____

Primary Diagnosis: _____ ICD10 code: _____

Date of 1st Treatment: _____ Dates of Subsequent Treatment: _____

Objective evidence supporting impairment (including x-rays, EKG's, lab data, physical exam notes, etc.):

_____

_____

_____

Limitation(s) or recommendation(s) related to impairment: _____

_____

_____

Do/Did you consider the patient to be unable to work? ❑ Yes ❑ No

If yes, please provide dates: From: _____ To: _____

If still completely unable to work, when do you expect the patient to be able to return to work?
❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ More than 12 months

Print or Type Name	Degree	Medical Specialty
Street Address	Telephone Number	Fax Number
City, State, Zip	SSN or Employer's ID #	
Signature of Physician		Date Signed
Is the physician, related to this patient? ☐ Yes ☐ No	If yes, relationship?	

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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 #: (_____) - _____ - _____

❑ Only Email - Please provide 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 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.

You understand that by selecting text messaging, regular text messaging rates may apply for any texts you receive from Trustmark and you assume responsibility for any costs associated with these text messages. You also understand and agree that by selecting text messaging or email, Trustmark may use either communication method to provide me with required written updates relating to my claim. This consent 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.

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

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, 100 North Pkwy, Worcester, MA 01605." 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, 100 North Pkwy, Worcester, MA 01605." 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, 100 North Pkwy, Worcester, MA 01605.

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 may 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.

Certificate Owner Signature	***Date***
Printed Name	***Last 4 Digits of SSN***

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State Required Fraud Warnings

Fraud Statement for the states of Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma Residents, 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 certificate owner or claimant for the purpose of defrauding or attempting to defraud the certificate owner 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, 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: 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 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 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 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.

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DISCLOSURE AUTHORIZATION

Patient's name (*Please Print***):** _____ **Last 4 Digits 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: _____

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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 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:_____ **SSN:** _____

Claimant 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

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

_____ Printed Name

_____ Printed Name

_____ Date

_____ Date

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Claim Submission Signature

The statements made by me on this claim are true and complete. 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 the state of New York: 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 of Certificate Owner: _____

Print Name of Certificate Owner: _____

I signed on behalf of the Certificate Owner, as _____ (relationship). If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Date signed: _____