Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Long Term Care / Home Health Care Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45750
For Claims Submission: 🖷 **Fax:** (508) 853-0310 ✉ **Email:** lifeclaims@trustmarkins.com

Instructions

If at any time you have questions about the completion of the enclosed claim form or the claim process, please call the above toll-free number. The purpose of this instructional document is to assist you through the claim handling process. There is important information that must be received in order to properly adjudicate your claim. Required information must be received in order for claim benefits to be considered. Providing incomplete information may lengthen the claim processing time.

Checklist for Claim Submission

- ❑ Complete claim form with as much detail as possible. Add additional pages if you need more room to respond to a question. Insured should complete Insured's Statement of Loss sections A through F. Physician should complete Attending Physician's Statement sections A through E.
- ❑ Provide a signed Healthcare or Durable Power of Attorney document if applicable.
- ❑ Provide a current copy of nursing home, assisted living or home health care agency license.
- ❑ Provide a signed Third Party Authorization if applicable allowing Trustmark to share the details of your claim to a spouse, child, sibling or friend, etc.
- ❑ Sign and date the enclosed Disclosure Authorization.
- ❑ Provide any testing or neuropsychological evaluations if completed.
- ❑ Attach any additional information you feel would help us understand your claim.

During the initial claim filing process, we may ask for additional information from you and/or your provider(s) to learn more about your condition and care needs.

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State Required Fraud Warnings

Fraud Statement for Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma Residents, as well as for Residents of 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 Arizona Residents: 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 Arkansas, Louisiana, New Mexico, Rhode Island, 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 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 District of Columbia, Maine, Tennessee, Virginia and Washington Residents: 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 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 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 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 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 New Jersey Residents: 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 Oregon Residents: 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 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.

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Insured's Statement of Loss

*To Be Completed Only By Insured or Authorized Representative – **Please Print*** ***Policy No:_____***

A. Contact Information

1. Insured Name: _____ Date of Birth: ____/____/____ Sex: M ☐ F ☐
   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:

   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 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: _____

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Name of Physician: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Condition(s) treated: _____

B. Information About Care

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

❑ Bathing ❑ Toileting ❑ Dressing ❑ Walking ❑ Eating ❑ Taking Medication ❑ Getting In & Out of Bed

Cognitive Impairment: ❑ Yes ❑ No

Type of Service Receiving				
Receiving This Service?	**Type of Agency/ Facility**	**Name & Address of Agency / Facility**	**Phone #**	**License #**
❑ Yes	Home/Health Care			
❑ Yes	Adult Care Center			
❑ Yes	Long Term Care			
❑ Yes	Assisted Living			
❑ Yes	Other			
If other please specify:				
If yes to any of above, please provide first date of treatment/confinement:				
If yes to either Long Term Care or Assisted Living, please provide the following:				
Tax ID of Facility:		Licensed By State? ❑ Yes ❑ No	License #:	
Licensed as what? (Please check)		❑ Skilled Nursing Care ❑ Intermediate Nursing Care ❑ Residential ❑ Other (Please specify):		

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

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.

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

_____ (_____)_____
Signature of insured **or** authorized/legal representative Phone

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C. 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 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 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 KS – this Authorization will be inforce for the duration of the claim or up to one (1) year, whichever comes first.

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.

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

Date: _____/_____/_____ Insured Signature: _____

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

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D. Communication - Electronic

1) 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 may communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with you electronically?

❑ No
❑ Yes, by Text Messages - Please provide cell phone #: (_____) - _____ - _____
❑ Yes, by Email Please provide email address: _____@ _____

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 by notifying Trustmark.

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

Should you prefer to submit your claims or claims information by U.S. Mail rather than email or fax, please use the following address: Trustmark Insurance P.O. Box 2906, Clinton, IA 52733

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.

_____ _____
Policy Owner Signature Date

_____ _____
Printed Name Social Security Number

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E. Communication- Third Party

Please complete this authorization if you would like us to discuss, to release, or to provide information to a third party regarding benefits under your policy. Note: Policy Owner and Claimant must give permission for disclosure of their information to each other, if applicable.

Policy Owner Name:_____

Claimant Name: _____

Policy Number(s): _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

□ **My Agent: (Name of Agent)** _____

□ All information (all policy and claim information)

□ Only the following information*: _____

□ **My Employer: (Name of Agent)** _____

□ All information (all policy 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 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 VBS_Disability@trustmarkins.com. This authorization is valid for 24 months. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____

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

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

_____ _____

Printed Name

Printed Name

_____/_____/_____

Date

_____/_____/_____

Date

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Attending Physician Statement

*To Be Completed Only By Attending Physician – **Please Print*** ***Policy 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 long term of home health care services?

   _____

   _____

   _____

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 long-term care or home health care services for this patient within the last 12 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 ☐ N

C. Functional Capacity

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

Please provide your opinion below as to what ADL loss, if any, your patient has experienced and indicate when this 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.

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Attending Physician Statement (*Continued*)

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 participates in process but **requires actual assistance from someone else** to complete the task.
3 = Individual is **mostly or completely dependent** on someone else for the task completion.

ADL	When did loss begin? (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 ____/____/_____	Select Value
Dressing ☐ No Loss	____/____/____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of ____/____/_____	Select Value
Taking Medication ☐ No Loss	____/____/____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of ____/____/_____	Select Value
Toileting ☐ No Loss	____/____/____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of ____/____/_____	Select Value
Eating ☐ No Loss	____/____/____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of ____/____/_____	Select Value
Transferring ☐ No Loss	____/____/____	☐ 0-30 days ☐ 31-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not anticipated Independent as of ____/____/_____	Select Value

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

D. Cognitive Capacity

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

If yes please complete following questions:

2. Does your patient have a cognitive impairment to the degree that it puts him/her at risk for health and safety?
   ☐ Yes ☐ No
   If yes, when did the cognitive impairment begin to impair your patient to the degree that it put him/her at risk for health and safety? (mm/dd/yy) _____

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3. Is your patient currently receiving supervision to protect his/her self or others due to cognitive impairment?
☐ Yes ☐ No
If yes, How many hours per day? _____ How many days a week? _____
When did the supervision begin (mm/dd/yy)? _____/_____/_____

Who provides the 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

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

Physician Name ***Please Print***

Last Name First Name Middle Initial

Address

City State Zip

( ) ( )
Telephone Number Fax Number

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

/ /
Signature of Physician **Date**