

# DISABILITY INCOME INSURANCE CLAIM APPLICATION

Trustmark Insurance Company  
100 North Parkway, Suite 200, Worcester, MA 01605  
Phone: 877-201-9373

This claim application is provided to assist you in submitting your claim for disability benefits. Please follow the directions carefully.

Your disability income policy requires prompt notification of claim. Your contract or certificate of insurance contains these requirements. By not notifying us promptly, you may cause a delay or limit our ability to determine your eligibility for benefits. In some cases, failure to promptly notify us could cause us to deny your claim. You should submit this completed claim application as soon as possible following the start of a disability, which is expected to last beyond your elimination period.

Please be sure to answer all the questions completely. Incomplete or ineligible answers may result in a delay in processing your claim. Your cooperation in continuously providing updated information will allow us to properly and effectively process this claim application.

Your application has four parts:

- 1) **Claimant's Statement:** Completed by the claimant. Be sure to sign and date in the section provided.
- 2) **Occupational Description:** Completed by claimant. A description of the duties of your occupation when your disability began is required to properly evaluate your disability and process your claim application.
- 3) **Attending Physician's Statement:** Completed by physician who is primarily responsible for your care. It is very important to have the dates of all treatments indicated in this part of your claim application. You should be sure to have your physician sign and date in the section provided.
- 4) **Signature Form:** This part of your claim application describes the laws governing insurance fraud in your state. Please be careful to read and understand the section appropriate to your state. To indicate that you have completed the claim application to the best of your knowledge and belief, sign and date in the section provided.

**In addition to the completed application, please submit any additional documentation, such as medical records, that you feel might be helpful in validating your claimed disability.**

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

For problems or questions regarding this claim application, please contact the Disability Claims Department of Trustmark Insurance Company at 1-877-201-9373.

Your completed claim application should be returned to:

Trustmark Insurance Company  
Disability Income Claims Department  
100 North Parkway, Suite 200  
Worcester, MA 01605

**CLAIMANT'S STATEMENT**

Policy # \_\_\_\_\_

1a. Name Last      First      Middle initial _____ / _____ / _____	2a. Date of birth Mo.    Day    Year _____ / _____ / _____	2b. Social Security Number -    - _____ - _____ - _____	2c. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
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1b. Address      Street (If PO Box, also show street address)	City	State	Zip	Telephone number
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2d. Height	Weight	3a. Spouse (please provide name)	3b. Dependents (please list and provide age)
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4a. Employer name _____ If you are a full or partial owner, indicate type of entity: C-Corp. <input type="checkbox"/> S-Corp. <input type="checkbox"/> LLC/LLP <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> In you are self employed, indicate Tax ID Number: _____	4b. Employer address _____ Telephone number _____
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4c. The following information is required by federal law:  
 If you are considered an employee, or if you are self-employed and your business is incorporated, does your employer pay any portion of your disability policy premiums?      Yes       No       If "Yes", what percentage? \_\_\_\_\_ %  
 Will your employer's contribution be included in your taxable income?      Yes       No

5. Medical Coverage Provider Name: _____ Provider: _____	6. Were you employed at the time of your impairment? Yes <input type="checkbox"/> No <input type="checkbox"/> Full time? Yes <input type="checkbox"/> No <input type="checkbox"/>	7. Annual income prior to disability? \$ _____
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8a. IF ACCIDENT,      Date occurred _____ b. Describe where and how it occurred and what injury resulted _____ _____ _____ _____ c. Have you had a similar injury?      Yes <input type="checkbox"/> No <input type="checkbox"/> d. If "Yes", please provide dates: _____	9a. IF SICKNESS,      Date occurred _____ b. Describe where and how it occurred and what manifestation of illness resulted _____ _____ _____ _____ c. Have you had a similar sickness?      Yes <input type="checkbox"/> No <input type="checkbox"/> d. If "Yes", please provide dates: _____
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10. Date of first treatment by a physician for this condition \_\_\_\_\_

11. Name & address of physician or hospital who first treated you for this condition.  
 \_\_\_\_\_  
 \_\_\_\_\_

12. If hospitalized, please provide dates and name of hospital \_\_\_\_\_

13. I have been unable to work:      From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

14. I first returned to my place of business or work since my impairment:      From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

15. I returned to work in a limited capacity:      From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CLAIMANT'S STATEMENT (continued)**

16. List any Physicians, Surgeons & Health Care Providers who have treated you during the past three years, beginning with your Primary Care Physician  
Please attach additional sheets, as needed.

Name	Specialty	Address	Telephone Number	Date 1 <sup>st</sup> Seen

17. Please list the name of all prescriptions/medications taken during the past three years:

Medication Name	Dosage	Prescribing Physician	Pharmacy Name	Telephone Number

18. Please check any and all benefits that you are eligible to receive.

	Applied for	Date applied for	Receiving	Amount received	Effective date
A. Social Security	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
B. Worker's Comp	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
C. State Disability Ins.	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
D. Retirement or Pension	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
E. Short Term Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
F. Salary Continuation	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
G. Unemployment	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
H. Union	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		

I. List all other companies with which you have disability coverage inforce.

Company name & Address	Policy number	Type of coverage	Date of issue	Amount of benefit

**OCCUPATIONAL DESCRIPTION**

A. Occupational title(s)	Number of hours worked in a normal week: _____
Nature of employer's business	Years with employer: _____
Supervisor's Name: _____	Years in occupation: _____
	If retired, date of retirement: _____

B. List the duties of your occupation(s) in order of importance providing as much detail as possible.

Duty _____	Hours spent each week _____
Description _____	
_____	

Duty \_\_\_\_\_ Hours spent each week \_\_\_\_\_

Description \_\_\_\_\_  
 \_\_\_\_\_

Duty \_\_\_\_\_ Hours spent each week \_\_\_\_\_

Description \_\_\_\_\_  
 \_\_\_\_\_

**C. Previous employment:**

Occupational Title	Employer Name & Address	Dates Employed
_____	_____	_____

**D. Indicate your highest level of academic training completed.**

High school \_\_\_\_\_ College (A.A.,A.S.,B.A.,B.S.) \_\_\_\_\_ Graduate program \_\_\_\_\_

Diplomas, certificates, licenses, journeyman cards: \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**F. Indicate the frequency of the following activities (check the appropriate boxes)**

Activity	Performed in job		
	Occasionally (0-33%)	Frequently (34-66%)	Constantly (67-100%)
Sitting			
Standing			
Climbing			
Stooping			
Kneeling			
Crawling			
Driving			
Handling			
Recognizing sounds with the ear			

Lifting

Usual number of pounds \_\_\_\_\_

Maximum number of pounds \_\_\_\_\_

Activity	Performed in job		
	Occasionally (0-33%)	Frequently (34-66%)	Constantly (67-100%)
Lifting			
Carrying			
Pulling			
Pushing			
Walking			
Reaching			
Balancing			
Fingering			
Sharpness of vision near and far			

Carrying

Usual number of pounds \_\_\_\_\_

Maximum number of pounds \_\_\_\_\_

**Fraud Statement for Alaska Residents:** A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Fraud Statement for Arizona Residents:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Fraud Statement for California Residents:** For your protection, California law requires the following to appear: **Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

**Fraud Statement for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Fraud Statement for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

**Fraud Statement for Kentucky Residents:** A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Fraud Statement for Arkansas, Louisiana, Texas, and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Statement for Minnesota Residents:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

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

**FRAUD STATEMENT FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**FRAUD STATEMENT FOR NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.**

**Fraud Statement for New Jersey:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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

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

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### Information Pertaining To Policy Premiums

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

- Yes**, please maintain my Trustmark policy(s) in force by withholding premiums while I am receiving benefit payments.
- No**, I will make the payments myself, as needed to maintain my policy(s).

Please review and sign both sections below.

**DISCLOSURE AUTHORIZATION**

Insured's name (Please Print): \_\_\_\_\_

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration, or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, [HIV Infection, any disorder of the immune system] [including] [Acquired Immune Deficiency Syndrome (AIDS),] driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Administration to release information or records about me to Trustmark Insurance Company or its authorized representatives. Such release of Social Security information will be used to adjudicate my claim in accordance with my policy benefits, or to continue my eligibility for benefits. I further request that the Social Security Administration release detailed earnings for up to the last ten years and/or a summary record of total earnings and/or information from master benefit records regarding award, denial or continuing Social Security benefits.

I understand that I may revoke this authorization at any time. Any such revocation is to be in writing, signed and dated by me, and must be forwarded directly to Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to me., A photocopy of this Authorization is as valid as the original and I may request a copy. This Authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below.

I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

**Residents of CA – the first sentence of the AUTHORIZATION is changed as follows: I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or persons having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employees and agents, or any consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me.**

**Residents of AZ - You or your authorized representative are entitled to receive a copy of this Disclosure Authorization.**

**Residents of MT – You are entitled to request a record of any subsequent disclosure of information.**

**Residents of NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.**

**Residents of NY – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Date: \_\_\_\_\_ Insured's Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship, if other than insured: \_\_\_\_\_

If I receive disability income payments greater than those, which should have been paid, I understand that I will be requested to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not returned.

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

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Print name: \_\_\_\_\_

Relationship, if other than insured

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

Name of patient \_\_\_\_\_ Date of birth \_\_\_\_\_  
Month Day Year

1. History

A. When did symptoms first appear, or when did the accident happen? \_\_\_\_\_  
Month Day Year

B. Has patient ever had similar conditions? Yes  No

If "Yes", please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Was patient referred to you by another physician? Yes  No

If "Yes", please list name, address and specialty \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Date you first advised patient to cease work? \_\_\_\_\_  
Month Day Year

E. Is condition due to injury or sickness arising out of patient's employment? Yes  No

F. Is condition due to pregnancy? Yes  No

If "Yes", please indicate estimated date of conception.....  
Month Day Year

G. Have you treated this individual for any other conditions? Yes  No

If "Yes", please describe including dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

H. Have you completed forms for other insurance carriers? Yes  No

If "Yes", please list insurance carriers \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Diagnosis (please include ICD or DSM-IV codes)

A. Primary diagnosis \_\_\_\_\_  
\_\_\_\_\_

B. Secondary diagnosis \_\_\_\_\_  
\_\_\_\_\_

C. Subjective symptoms \_\_\_\_\_  
\_\_\_\_\_

D. Objective finding (including the results of X-rays, ECG's, laboratory data, and any clinical findings)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Treatments**

A. Nature of treatment (including surgery, medications prescribed and specialty referrals) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

B. Date of first treatment for this condition? \_\_\_\_\_  
 Month Day Year

C. Dates of subsequent treatment  
 \_\_\_\_\_  
 Month Day Year    Month Day Year    Month Day Year    Month Day Year

D. Has patient been hospital confined? Yes  No   
 If "Yes", please provide name and address of hospital \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 From: \_\_\_\_\_  
 Month Day Year  
 To: \_\_\_\_\_  
 Month Day Year

E. Future treatment plans \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**4. Extent of impairment**

A. In your opinion, do you consider the patient to be unable to work in his/her occupation? Yes  No

B. If "Yes", please provide dates From \_\_\_\_\_ To \_\_\_\_\_  
 Month Day Year    Month Day Year

C. If still completely unable to work when do you expect the patient will be able to return to his/her work duties?  
 1-3 months  3-6 months  6-12 months  More than 12 months

D. If patient is able to do some work, how long before patient will be able to work without restrictions?  
 From \_\_\_\_\_ To \_\_\_\_\_  
 Month Day Year    Month Day Year

E. What are the patient's current specific limitations? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Physical impairment (as defined in the Federal Dictionary of Occupational Titles)**

- No limitations of functional capacity; capable of heavy work; No Restrictions.
- Capable of medium manual activity
- Slight limitation of functional capacity; capable of light work
- Moderate limitation of functional capacity; capable of clerical/administrative or sedentary activity
- Severe limitation of functional capacity; incapable of minimal (sedentary) activity

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

**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.

Physician's name (please print)	Degree	Specialty	Telephone #
Street address	City/town		State/Province    Zip
Signature	Date		Fax #