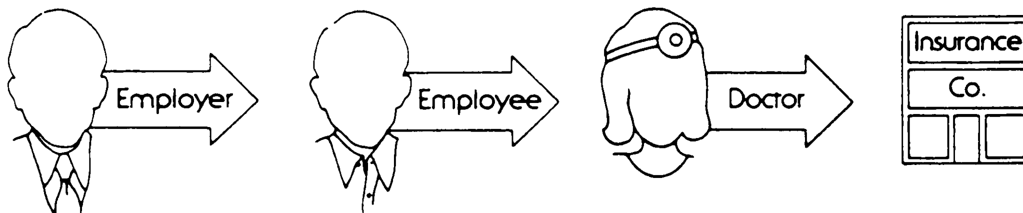
Trustmark
LIFE INSURANCE COMPANY

P.O. Box 7948 • Lake Forest, IL 60045-7948
Phone 1-800-290-8899 • Fax (847)615-3866

Group
Long Term Disability
CLAIM

POLICYHOLDER CERTIFICATION



EMPLOYER – *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 60 to 90 days prior to the end of the elimination period:

A. Complete the back of this form in full and transmit this portion only to address above.

Include:
- Job description (detailed duties)
- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed include copy of First Report of Accident and the decision

B. Give remaining two-part form to claimant for completion.

Request:
- Birth certificate (short duration claim and under age 50 not necessary at this time)
- Copy of awards from other source of benefits: Social Security, Workers' Comp., retirement, state disability, others

C. If claimant has more than one treating physician, give claimant additional forms for completion.

D. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

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EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

1. Employee's Name
2. Social Security No.
3. Date of Birth
4. Address City State Zip Code
5. Email Address

EMPLOYMENT

6. Insurance Class
7. Employee Date of Hire
8. Date employee became Insured for LTD
9. Date employee was actually last present at work
10. Occupation at time last worked (attach job description)
11. Work schedule at time last worked
    No. of days per week ________ No. of hours per day ________
12. Reason for stopping:
    ☐ Sickness ☐ Granted LOA ☐ Laid Off
    ☐ Retired ☐ Dismissed ☐ Other
    ☐ Resigned ☐ Vacation
13. Has employee returned to work?
    ☐ Yes ☐ Part-time ☐ Full-time
    ☐ No Date ________ Date ________

INCOME

14. How is employee paid?
    ☐ Straight Salary ☐ Hourly
    ☐ Salary & Commissions
    ☐ Commissions Only ☐ Salary & Bonus
15. Employee's Basic Monthly Earnings
    $ ________ LTD Benefit ________
    (If salary is based on less than 12 mos. - No. of mos. ________)
16. Employee's % of LTD premium contribution: Employee pays ________ Employer pays ________

OTHER BENEFITS

17. Has insured received other disability payments since time last worked?
    Salary Continuance: ☐ Yes Wkly. Amt. ________ Date benefits cease ________ ☐ No
    Insured Short Term: ☐ Yes Wkly. Amt. ________ Date benefits cease ________ ☐ No
    Other Type: ________ ☐ Yes Wkly. Amt. ________ Date benefits cease ________ ☐ No
18. Did claim result from job activity:
    ☐ Yes (Explain)
    ☐ No
19. Has Workers' compensation claim been filed?
    ☐ Yes
    ☐ Pending
    ☐ Denied (Enc. copy)
20. Workers' compensation Wkly. Amt.
    $ ________
    (Inc. copy of 1st report of accident)

RETIREMENT

21. Is employee covered by employer sponsored retirement plan? ☐ Yes ☐ No
22. Does retirement plan contain a disability provision? ☐ Yes ☐ No
23. Is employee or will this employee be eligible for a disability or retirement pension? ☐ Yes ☐ No
    If "Yes" type:
    Monthly Amount $ ________
    ☐ Disability
    ☐ Retirement
    ☐ Other
    Commence Date of Benefits:
    (enclose copy of summary plan description)

NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.

CERTIFICATION

24. Employer's Name (state association and name of policyholder, if other)
25. Telephone No.
26. Group Policy No.
27. Address
28. Employer (Taxpayer) I.D. Number (EIN) ________ – ________
    OR
29. Public Employer Social Security No. 69 ________ – ________
30. Name of person completing this form (please type or print)
31. Signature of Authorized Insurance Representative Title Date

Separate and send this form (with other enclosures) to address on reverse side. Give remaining portions of form to claimant for completion.

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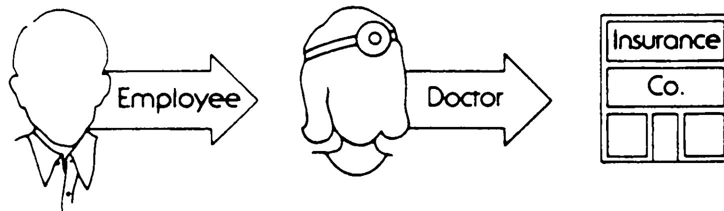
Group
Long Term Disability
CLAIM

APPLICATION



EMPLOYEE – *form completion information*

Application for Group LTD — Instructions

A. Complete and sign the authorization on the reverse side of this page. If you have more than one provider, please complete an authorization for each provider. This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).

B. Completion employee claim statement in full.

Attach:
- A copy of your birth certificate if disability is indefinite
- A copy of Social Security and other income entitlement awards (or forward when received)

C. Give this authorization and attached claim application to the physician treating you (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.

D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

Do Not Detach

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

Patient Name:____________________ Street Address: ____________________

City: ____________________ State: ________ Zip Code:________ Date of Birth: ________

I authorize: ____________________
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

Release to: **Trustmark Life Insurance Company**
P.O. Box 7948
Lake Forest, IL 60045-7948

Specify Dates or date ranges: ____________________

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Health care provided to me; or
- Payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to **Trustmark Life Insurance Company** (herein as referred to "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments, tests as well as any information regarding drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, or any other public or private entity as may be lawfully required. The information provided to **Trustmark Life Insurance Company,** its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be as valid as the original.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or insurance fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

____________________ ____________________
Claimant Signature/Legal Representative Date

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GROUP LONG TERM DISABILITY CLAIM APPLICATION

TO BE COMPLETED BY EMPLOYEE

CLAIMANT

1. Full Name (Last, First, Middle Init.)
2. Social Security No.
3. Phone Number
4. Address | City | State | Zip Code
5. Email Address
6. Date of Birth — Mo. Day Year
7. Height
8. Weight
9. Sex ☐ M ☐ F
10. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
11. Spouse's date of birth — Mo. Day Year — First Name
12. Is spouse employed? ☐ Yes ☐ No
13. Number of children (under age 19)
14. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

15. Employer's Name
16. Group Policy No.
17. Occupation (List the duties of your occupation at the time of disability)
18. Date of accident or date first noticed symptoms of illness: — Mo. Day Year
19. I have been unable to work because of the disability since: — Mo. Day Year
20. I returned to work on a part time basis on: — Mo. Day Year
21. I returned to work on a full time basis on: — Mo. Day Year
22. Is your accident or illness related to your occupation? ☐ Yes ☐ No
23. If "yes," explain

Have you or do you intend to file a Workers' Comp. Claim? ☐ Yes ☐ No

CLAIM HISTORY

24. Describe how and where accident occurred or describe the onset and nature of your illness.
25. Date you were first treated for your illness or injury — Mo. Day Year
26. Treated by:

Hospital: ______________________
Name Street Address City State Zip Code

Doctor: ______________________
Name Street Address City State Zip Code

27. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No

If yes complete No. 28.

28. Treated by:

Hospital: ______________________
Name Street Address City State Zip Code

Doctor: ______________________
Name Street Address City State Zip Code

INCOME

29. Describe other income you are receiving:

yes	no	type	amount	date began	date term.
☐	☐	Social Security (disability or retirement)	$ ________	________	________
☐	☐	State disability	$ ________	________	________
☐	☐	Retirement (normal, early or disability)	$ ________	________	________
☐	☐	Workers' Compensation	$ ________	________	________
☐	☐	Group disability benefits	$ ________	________	________
☐	☐	Other (describe) ________	$ ________	________	________

BENEFIT

30. Have you, or do you plan to apply for benefit described above?

Type ______________________ Date application filed ______________________
Type ______________________ Date application filed ______________________

31. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes? ☐ Yes ☐ No If "yes" Amt. $ ________
Indicate amount per month $80.00 min.

____
Signature

- over -

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, Oregon, and Vermont 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
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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 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, Tennessee and Virginia
WARNING: 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 RSA 638:20.

Fraud Statement for New Mexico and Pennsylvania Residents
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Fraud Statement for New Jersey Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Delaware, Idaho, Indiana, Ohio, 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.

Fraud Warning for 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 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.

The information that I have provided on this claim form is true and complete to the best of my knowledge and belief

______________________________ ____________________

Signature of Employee Date

ATTENDING PHYSICIAN'S STATEMENT

Return To: Trustmark Life Insurance Company
P.O. Box 7948
Lake Forest, IL 60045-7948
1-800-290-8899 • Fax: 847-615-3866

Name of Patient | Date of Birth

HISTORY

(a) When did symptoms first appear or accident happen?
(b) Date patient ceased work because of disability?
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe.
(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications)
(b) If pregnancy, est. date of delivery
(c) Subjective symptoms
(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

TREATMENT

(a) Date of first visit
(b) Date of last visit
(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify)
(d) Nature of treatment (Including surgery and medications prescribed, if any)
(e) Specific restrictions and limitations

PROGRESS

(a) Has patient? ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
(b) Is patient? ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?
(c) Has patient been hospital confined? ☐ Yes ☐ No
If yes, give Name and Address of Hospital
Confined from __________ through __________

CARDIAC

(a) Functional Capacity (American Heart Association)
☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation)
☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
(b) Blood Pressure (Last Visit)
____
Systolic/Diastolic

IMPAIRMENTS

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)
☐ Class 1 – No limitation of functional capacity; capable of heavy work*. No restrictions. (0 – 10%)
☐ Class 2 – Medium manual activity*. (15 – 30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work*. (35 – 55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 – 70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 – 100%)
Remarks: __________

(b) Mental Impairments (If Applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?
☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
Remarks: __________

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No
(b) Date patient became disabled due to present illness
(c) When do you expect a fundamental or marked change in the future?
☐ 1 Month ☐ 1 – 3 Months ☐ 3 – 6 Months ☐ Never
Applies To: ☐ Patient's Job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No
(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No
(c) When could trial employment commence?
Date: __________ ☐ Full-Time ☐ Part-Time — PATIENT'S JOB
Date: __________ ☐ Full-Time ☐ Part-Time — ANY OTHER WORK

REMARKS

Reason unable to work, in detail

Name (ATTENDING PHYSICIAN) Print	Degree	Telephone	
Street Address	City or Town	State or Province	Zip Code
Signature	Tax identification #		Date