

We understand that you wish to file a claim for benefits. We have therefore enclosed a claim form for completion.

The claim form consists of 4 sections. To avoid any delays in the processing of your claim please be sure that all sections of the claim form are fully completed:

- 1) The **Claimant's Statement**: this section should be completed by you and includes your current contact information, description of the events related to your claim, your treatment providers and information relating to your job and other disability coverage.
- 2) The **Disclosure Authorization**: this section should be completed by you. Be sure to sign and date where indicated.
- 3) The **Attending Physician's Statement**: this section should be completed by the doctor who is providing the care for your claimed condition and includes date(s) of treatment, the current diagnosis, and any periods you have been unable to work due to your medical condition.
- 4) The **Employer's Statement**: this section should be completed by your employer and includes job specific information to include your last day worked, salary and reason off work.

Once we receive your fully completed claim form we will contact you in writing within 48 hours verifying our receipt of your claim and letting you know the name and contact information for the representative who will be working with you directly. You should expect to be contacted by your representative within 10 business days. Your claim representative will outline the provisions of your policy, explain the claim process and advise you of any additional information which may be required to complete the review process.

Prior to returning the claim form to this office, please be sure that all sections are completed in full. Failure to provide all of the information requested may result in a delay in benefits.

It is very important for you to continue to make premium payments while we determine your eligibility for benefits. If you have been paying your premium through payroll deductions and you are longer receiving a paycheck, please contact the Family Security Plan at 800-243-2292 to arrange for your billing. If your premiums are not paid current, we may reduce any potential benefit payment by the amount of premium owed. In addition, if your premiums are not paid current your policy may lapse.

If you have any questions concerning your claim, please do not hesitate to contact the Claim Department directly at 877-201-9373.

Sincerely,

Trustmark Insurance Company
Disability Benefits

IMPORTANT: PLEASE SIGN AND DATE AUTHORIZATION ON THE FINAL PAGE OF THIS FORM

CLAIMANT'S STATEMENT *To be completed by Insured* **Policy #**

Last Name _____ First _____ MI _____ Soc. Sec. No. _____ Birth Date ____/____/____ Gender: M F
 Address _____ Apt No. _____ City _____ State _____ Zip _____
 Telephone No. _____ Spouse's Name _____ Dependents (please list & provide ages) _____
 Employer Name & Address: _____ Telephone Number: _____

Were you employed at the time of your impairment? Yes No Full-Time? Yes No Annual gross income prior to disability? \$ _____

Accident Sickness Date Occurred ____/____/____

Describe where & how it occurred & what illness/injury resulted: _____

Have you had a similar illness/injury? Yes No If yes, date(s) _____

Date of first treatment by a physician for this condition ____/____/____ Work Related Yes No

Name & Address of physician or hospital who first treated you for this condition: _____

If hospitalized, provide dates and name of hospital: _____

I was unable to work from: ____/____/____ To ____/____/____ I returned to work in a limited capacity from ____/____/____ To ____/____/____

List any Physicians, Surgeons & Health Care Providers who attended to you and/or Pharmacies you have utilized during the past 3 years. Attach additional sheets if needed.

Name:	Address	Phone#	Reason	Dates
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any periods of hospitalization you have had during the past 3 years:

Hospital Name: _____ Dates of hospitalization: _____

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Please indicate any benefits that you are eligible to receive:

Source	Amount	Date Applied	Payments Began	Payments End	Source	Amount	Date Applied	Payments Began	Payments End
State Disability	\$ _____	____/____/____	____/____/____	____/____/____	Soc. Sec.	\$ _____	____/____/____	____/____/____	____/____/____
Workers' Comp	\$ _____	____/____/____	____/____/____	____/____/____	Unemployment	\$ _____	____/____/____	____/____/____	____/____/____
Retmnt/Pension	\$ _____	____/____/____	____/____/____	____/____/____					

If you have other disability insurance coverage please complete the information below:

Company Name _____ Policy # _____ Benefit Amount/month \$ _____ Effective date of Coverage ____/____/____

Company Name _____ Policy # _____ Benefit Amount/month \$ _____ Effective date of Coverage ____/____/____

Occupation

Occupational Title(s) _____ # of hours worked in a normal week _____ Nature of employer's business _____

Supervisor's Name: _____ Years with employer _____ Years in occupation _____ If retired, date of retirement ____/____/____

Please check off how frequently you were paid by your employer: Weekly Bi-Weekly Semi-Monthly Monthly

Please provide a description of your occupation to include your important duties (attach separate sheet if necessary)

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

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			
Walking			
Driving			

Activity	Performed in job		
	Occasionally (0-33%)	Frequently (34-66%)	Constantly (67-100%)
Lifting			
Carrying			
Pulling			
Pushing			

Lifting: Usual number of pounds _____ Maximum number of pounds _____ Carrying: Usual number of pounds _____ Maximum number of pounds _____

EMPLOYER STATEMENT To Be Completed By Employer

Please Attach Job Description

Employee's name _____ Hire Date ____/____/____ Birth Date ____/____/____ Job Title _____

Date employee last worked ____/____/____ If terminated: Date ____/____/____

Reason not working: Sickness Injury Retired Resigned Granted LOA Dismissed Vacation Laid Off Other _____

Is the present condition the result of an accident or injury on the job? Yes No If yes, date of accident ____/____/____

Has a Workers Compensation Claim Been Made Yes No Job Classification: Heavy Labor Moderate Labor Light Labor Sedentary/Clerical Labor

Hours worked during the week _____ Check regular work schedule __ S __ M __ T __ W __ T __ F __ S

Date employee returned to Regular duties: F/T ____/____/____ P/T ____/____/____ Light duties: F/T ____/____/____ P/T ____/____/____

Employee's gross monthly earnings preceding disability Base: \$ _____ O/T: \$ _____ Is salary based on 12 months? oYes o No ____ mos.

Was employee absent from work for any reason, other than vacation or pregnancy, during the period of: _____ thru _____ Yes No

(Please note the above dates will not be the same as the current disability)

If Yes: Date: _____ Cause: _____

Date: _____ Cause: _____

Employer _____ Telephone _____ Fax _____

Address _____

Signature _____ Title _____ Date _____

ATTENDING PHYSICIAN STATEMENT

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 ____/____/____ Date symptoms first appeared or accident happened ____/____/____

Date patient ceased work because of impairment ____/____/____ Date of first treatment ____/____/____ Dates of subsequent treatments _____

CHECK YOUR RESPONSES: Is this condition due to an Accident a Sickness? Is the accident or sickness related to the patient's employment? Yes No

Is condition due to pregnancy Yes No Est. Date of Delivery: ____/____/____ Delivery Type: Vaginal C-Section

Was patient referred to you by another physician? Yes No If yes, please list name, address, and specialty _____

Primary diagnosis _____ Subjective symptoms _____

Objective findings (including the results of X-rays, EKG's, laboratory data, and any clinical findings) _____

Has patient been hospital confined? Yes No From ____/____/____ To ____/____/____ If yes, Hospital name _____

Do you consider the patient to be completely unable to work in his/her occupation? Yes No If yes, please provide dates From ____/____/____ To ____/____/____

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

If patient is able to do some work, for what period will patient be restricted from his normal duties? From ____/____/____ To ____/____/____

What are patient's current limitations? _____

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

Have you completed claim forms regarding this patient for other insurance carriers? Yes No If Yes, Name of insurance company: _____

Physician's name (please print) _____ Degree _____ Specialty _____ Phone _____

Address _____

Signature _____ Date ____/____/____ Fax # _____

Fraud Statement for Alaska and 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 AZ 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 CA 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 CO 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 FL 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 KY 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 Louisiana, Maryland, New Mexico, 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 MN 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, VIRGINIA AND WASHINGTON 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 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 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.

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, 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 term of coverage of the policy or up to 12 months from the date shown below, 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 not 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 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.

RESIDENTS OF ME: 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.

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