Group Accident Claim Form

For Claims Customer Service: ☎ **Phone:** (866)-813-7192
For Claims Submission: 🖷 **Fax:** (866) 680-0397 ✉ **Email:** GroupAccidentClaimsVB@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.

Please be sure to include proof of treatment including itemized copies of any doctor, emergency room hospital and motor vehicle/accident reports or records, complete hospital intake and discharge statement(s), UB-04 insurance billing form, HCFA or CMS 1500 billing form.

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 following required supporting documentation in your claim submission.

- Proof of treatment including medical records describing treatment date and diagnosis, complete hospital intake and discharge statement(s), itemized copies of any doctor, emergency room and/or hospital bills, UB-04 insurance billing form, HCFA or CMS billing form.
- If surgery was done, please provide a copy of the operative report.
- If claiming a fracture, please include an imaging report, such as an x-ray, showing the fracture.
- For a laceration, please include the length and proof of stitches if received.
- For Lodging/Transportation benefit(s), please include copies of mapping, such as google maps, to document mileage to facility/treatment, and hotel bills for lodging.
- If accident was the result of a MVA (motor vehicle accident), please provide complete copy of motor vehicle accident/police report.
- If accident happened at work, please provide a copy of the work incident report.
- Other proof of treatment may 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, C & D** – To be completed by the certificate owner.
- **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 test or email, including text alerts for any payments released.
- **Third Party Communication Authorization** – To be completed by the certificate owner. 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 _____

Address: _____
Street City State Zip Code

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

Section C – Accident Details

Accident Date: _____ Place of Accident (city/state): _____

Type of Accident:

❑ Motor Vehicle Accident *(Please provide copy of accident/police report)*	❑ Cut / Laceration
❑ On the Job Injury *(Please provide copy of work incident report)*	❑ Allergic Reaction
❑ Sports Related	❑ Infection
❑ Slip/Trip/Fall	❑ Overuse
	❑ Fight
	❑ Other _____

Where did Accident take place:

❑ Car	❑ School	❑ Park
❑ Home	❑ Parking Lot	❑ Aircraft
❑ Work	❑ Street	❑ Racetrack
❑ Gym	❑ Restaurant	❑ Other _____

Onset of Injury:

❑ Immediate	❑ Days Later	❑ Retriggered Previous Injury
❑ Later that day	❑ Weeks Later	❑ Unknown
❑ Next Day	❑ Months Later	

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Diagnosis / Description: Please provide a description of the accident including where the accident occurred and what happened to the patient.

Treatment Information: Please provide proof of treatment including medical records describing treatment date and diagnosis.

Date of Initial Treatment	**Location**	**Name & Address of Facility**
	❑ Walk-In Clinic ❑ Emergency Room (ER) ❑ Doctor's Office ❑ Other _____	
Date of Follow-Up Treatment	**Location**	**Name & Address of Facility**
	❑ Walk-In Clinic ❑ Emergency Room (ER) ❑ Doctor's Office ❑ Other _____	

Hospital Confinement: If the patient was admitted to the hospital, please provide the following information. Please provide documentation showing reason for admission, admission and discharge date and room type.

Admission and Discharge Dates	**Room Type**	**Name & Address of Hospital**
Admission Date: _____ Admission Time: _____ Discharge Date: _____ Discharge Time: _____	❑ Observation Unit ❑ Regular Room ❑ ICU ❑ Rehab ❑ Other _____	
Admission Date: _____ Admission Time: _____ Discharge Date: _____ Discharge Time: _____	❑ Observation Unit ❑ Regular Room ❑ ICU ❑ Rehab ❑ Other _____	

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Physical Therapy: Please complete the below if you are claiming physical therapy. Please provide documentation of visit dates, reason for visit and where physical therapy was performed.		
Visit Dates	**Name of Facility**	**Address of Facility**
Initial Visit Date: _____		
Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____		
Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____ Follow-up Date: _____		

Fracture or Dislocation: Please complete the below if you are claiming a fracture or dislocation. Please provide proof of fracture or dislocation and if surgery was required, a copy of the operative report.		
Bone	**Surgery**	**Anesthesia**
	❑ Surgery Required ❑ No Surgery	❑ Anesthesia Required ❑ No Anesthesia
	❑ Surgery Required ❑ No Surgery	❑ Anesthesia Required ❑ No Anesthesia
	❑ Surgery Required ❑ No Surgery	❑ Anesthesia Required ❑ No Anesthesia
	❑ Surgery Required ❑ No Surgery	❑ Anesthesia Required ❑ No Anesthesia

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Surgery Benefit: If surgery was performed due to a Covered Accident for anything other than a fracture or dislocation, benefits may be payable. Please complete below if you are claiming the surgery benefit. A copy of the operative report is required.

Type of Surgery	Date of Surgery and Name of Surgery Performed	Name of Facility	Address of Facility
Arthroscopic Surgery	Surgery Date: _____ Surgery Performed:		
Cranial Surgery	Surgery Date: _____ Surgery Performed:		
Hernia Surgery	Surgery Date: _____ Surgery Performed:		
Herniated Disc Surgery	Surgery Date: _____ Surgery Performed:		
Open Abdominal or Thoracic Surgery	Surgery Date: _____ Surgery Performed:		
Tendon / Ligament / Rotator Cuff Surgery	Surgery Date: _____ Surgery Performed:		
Torn Knee Cartilage Surgery	Surgery Date: _____ Surgery Performed:		
Other Surgery	Surgery Date: _____ Surgery Performed:		

Was General Anesthesia Used? ❑ Yes ❑ No Was Conscious Sedation Used? ❑ Yes ❑ No

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Other Benefits: Please complete below for other benefits you are claiming. Not all benefits may be available under your certificate. Please provide documentation for claimed benefits such as medical records or invoices.		
Was appliance prescribed by a physician?	❑Yes ❑No	What appliance?
Was an ambulance required?	❑Yes ❑No	❑ Ground ❑ Water ❑ Air
Were Diagnostic Tests Done?	❑Yes ❑No	Test Name(s) & Date(s)
Was the patient in a coma?	❑Yes ❑No	Date: Facility:
Did the patient receive an epidural?	❑Yes ❑No	Date: Facility:
Was the patient diagnosed with a concussion?	❑Yes ❑No	Date: Facility:
Did patient suffer a burn?	❑Yes ❑No	Degree of Burn: % of Body Surface:
Did patient require a skin graft	❑Yes ❑No	Date: Facility:
Did patient require emergency dental work?	❑Yes ❑No	What Type? Date: Facility:
Did the patient suffer an eye injury?	❑Yes ❑No	What Type? Date: Facility:
Did the patient suffer a gunshot wound?	❑Yes ❑No	Date: *Note: Police report is required*
Did the patient suffer a laceration?	❑Yes ❑No	Length: Was it repaired: ❑ Yes ❑ No
Did the patient travel more than 50 miles from primary residence to receive treatment or be confined to a hospital?	❑Yes ❑No	Date(s): Facility:
Did an adult companion accompany the patient to receive treatment or be confined to a hospital and require an overnight stay?	❑Yes ❑No	Date(s): Medical Facility: Lodging Facility: *Note: Proof of lodging is required*
Did the patient suffer a traumatic brain injury?	❑Yes ❑No	Date: Facility:
Did the patient die as a result of the accident?	❑Yes ❑No	Date: *Note: Death Certificate is required*
Was patient a passenger in a commercial airline, train, bus, trolley, subway, ferry or boat that operates on a regularly scheduled basis between predetermined points or cities at time of accident?	❑Yes ❑No	Which one?
Did the patient suffer a catastrophic loss?	❑Yes ❑No	What did patient lose use of?

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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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Information Pertaining to Premiums
In order to prevent the loss of your insurance coverage and to allow payment of benefits due, it is necessary to have any premiums due paid appropriately.

For coverage under which benefits claimed:
If premium is more than 30-days behind your claimed date of loss, past due premiums will be deducted from any benefits paid.

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: ____-____-____