Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Death Benefit Claim

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

Instructions

- The ***Statement of Attending Physician*** section must be completed by the deceased's primary care physician, **ONLY** if the death occurred within the first two (2) years from the effective date of the policy.
- The ***Statement of Beneficiary*** must be completed by the person to who the insurance is payable. In connection with such statement, the following should be observed:
    1. If there is ***more than one beneficiary***, all may join in one statement or a separate form will be furnished for each if desired.
    2. If the policy is ***payable to the estate or to the executors or administrators of the insured***, the Beneficiary Statement should be completed by the executor or administrator, a certificate of whose appointment and qualifications must be furnished.
    3. The ***Disclosure Authorization*** should be completed by the executor or administrator of the insured's estate. If there is no executor or administrator, the Disclosure Authorization should be completed by the next of kin. Any supporting documentation (i.e. executorship paperwork) should be furnished.
    4. If the policy is ***payable to a minor or a mentally incompetent person***, the statement should be completed by a guardian, a certificate of whose appointment and qualifications must be furnished.
    5. If the policy has been ***assigned***, special instructions will be furnished.
- Copies of recent medical records and/or testing results may also be helpful.
- A ***Certified Copy of the Death Certificate showing cause and manner of death*** must be furnished for ***insured.***
- A ***Certified Copy of the Death Certificate*** for any ***deceased beneficiary*** must be furnished.
- If the cause of death is due to an injury or accident, please enclose a photocopy of the police report and/or newspaper articles concerning the circumstances.

Section A – Statement of Beneficiary

Policy / Certificate #: _____

Deceased's Full Name: _____ Deceased's DOB: ____/____/____

Residence Address: _____
Street City State Zip Code

Date of death? ____/____/____ Place of death: _____

Cause of death: _____

Was deceased confined to a hospital at time of death? ❑ Yes ❑ No

If yes, where? _____

Names & addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death			
Physician Name	**Address**	**Phone/Fax #'s**	**Disease or Condition**

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Section A – Statement of Beneficiary (Continued)

Names of any medications prescribed for deceased within the five years preceding death		
Medication Name	**Reason Prescribed**	**Pharmacy Where Filled**

If optional settlement is available, and you do not desire payment in one sum, state type of settlement desired: _____

_____

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Section B – Statement of Attending Physician *(To be completed by the Attending Physician)*

Deceased's Full Name: _____ Date of Birth: _____

How long have you treated the deceased? _____

Date of death? ____/____/_____ Place of death: _____

When you were first consulted for the condition which directly or indirectly caused death: ____/____/____

Immediate cause of death? _____ Duration: _____

Contributory cause of death: _____ Duration: _____

Other chronic diseases, conditions or impairments:_____ Duration: _____

In the past 36 months did the deceased smoke or use tobacco products: ❑ Yes ❑ No

Please give particulars of any condition, chronic disease or impairment for which you treated or advised deceased prior to last illness

Disease or Condition	Date	Duration	Result

Please give name & addresses of all other physicians or other practitioners who attended deceased within the five years preceding death

Physician Name	Address	Phone	Disease or Condition

Names of any medications prescribed for deceased within the five years preceding death

Medication Name	Reason Prescribed	Pharmacy Where Filled

Physician's name (please print)_____ Specialty_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Address: _____
Street City State Zip Code

Signature_____ Date ____/____/____

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State Required Fraud Warnings

Fraud Statement for Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma Residents, as well as for Residents of all States not Specifically Listed: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud, which is a crime."

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

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

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

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

Fraud Statement for District of Columbia, Maine, Tennessee, Virginia and Washington Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

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

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

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

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

Fraud Statement for Oregon Residents: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing materially false or misleading information may be guilty of insurance fraud.

Fraud Statement for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files any application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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DISCLOSURE AUTHORIZATION (To be completed by next of kin or excutor or administrator of estate. Please provide copies of any applicable executorships or estate)

Insured's Name (Please Print):_____ **SS#** _____

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

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

I understand that I may revoke this authorization at any time. Any such revocation is to be in writing, signed and dated by me, and must be forwarded directly to Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to me, A photocopy of this Authorization is as valid as the original and I may request a copy. I understand that if I choose I may request a copy of any credit report Trustmark receives in connection with this authorization. This Authorization will be in force for the duration of the claim or up to 12 months from the date shown, whichever time period is less. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality**.**

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

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

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

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

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

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

Signature: _____ Date Signed: ___/___/___

Printed Name: _____ Date of Birth: ___/___/___ SSN: _____

Relationship: _____ Daytime Phone Number (____) _____-_____

Residence Address: _____
Street City State Zip Code

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Beneficiary Statement of Claim – Communication

CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS TEXT MESSAGING)

To ensure the best and fastest communication, we would like to communicate with you using either email or text messaging. Please complete this section if we can communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with you electronically?

❑ No

❑ Yes, by Text Messages - Please provide cell phone #: (_____) - _____ - _____

❑ Yes, by Email Please provide email address: _____@ _____

If you chose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents, have access to electronic communication between you and us.

I understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Trustmark and I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked by notifying Trustmark.

To ensure a smooth email experience, please be sure that your computer has the most up to date version of Adobe Reader. You should add our email address to your address book contact list and add us to your email server or spam filter approved listing. If you don't see email from us in your email inbox, be sure to check your spam, clutter, junk or bulk email folder. You can choose to stop electronic communication at any time by revoking this authorization. If you no longer wish to communicate via electronic means we will correspond with you via US mail. If you require copies of any communication sent to you by email/text in paper form, please contact us. There is no cost to you to obtain copies of electronic communication in paper format.

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

Authorization

I may revoke or update this authorization at any time by notifying Trustmark.

This authorization is valid for 24 months. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____

Policy Owner or Beneficiary Signature ***Date***

_____ _____

Printed Name ***Social Security Number***