Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Healthy Living Rider Claim

For Claims Customer Service: ☎ **Phone:** 877-201-9373 x45704
For Claims Submission: 🖷 **Fax:** (508) 471-3208 ✉ **Email:** RiderClaims@Trustmarkins.com

Instructions for Claim Submission

Please be sure to attach copies of *Outpatient Bills / Invoices* or *Explanation of Benefits* to support the testing/services you had completed.

Please complete a SEPARATE form for each individual and/or calendar year that you are claiming benefits.

- **Section A, B & D -** Complete these sections and return to us for review of benefits. All questions must be answered in full. ***Incomplete or illegible answers may result in delay of benefits***. Please keep a copy of all parts of this form and any attachments for your records.
- **Section C-** Complete this section only if as the result of a covered test or service you required and received a follow-up diagnostic test.
- **Section E –** Complete only if services provided through an employer sponsored wellness clinic for which you have no other documentation.
- **Insured Statement of Claim – Consent For Use of Electronic Communications:** Complete this if you would like to authorize Trustmark to alert you via text when any payment is processed.

- **Electronic Communication and State Required Fraud Language:** Attached for your information.
- **Third Party Communication Authorization:** Please complete the Third Party Authorization if you would like to authorize Trustmark to discuss and/or release information to a third party, including a spouse, friend or agent. Note, Policy Owner and Claimant must give permission for disclosure of their information to each other, if applicable.

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.

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Section A – Policyholder Information *(To Be completed by the Policy Owner)*

Policy #: _____ SSN#_____/____/_____

Name: _____ DOB: ____/____/____ Phone #_____❑Home ❑Cell ❑Work

Address: _____
Street City State Zip Code

Employee of Trustmark Companies?: ❑ Yes ❑ No Language Preference ❑ English ❑ Spanish

Section B – Patient Information *(To Be completed by the Policy Owner)*

Please complete below and attach itemized copies of any related bill supporting the testing you or the patient had completed.

Name of patient: _____ DOB: _____/____/____ SSN: _____-_____-_____

Relationship to Insured: _____ (e.g. spouse, son, daughter)

This is not a guarantee of payment. Benefits will be determined based on your policy provisions and the provisions of your Healthy Living Rider.

Please advise which routine service you had completed by providing the date it was completed in the section below.

Routine Service	Date Completed	Routine Service	Date Completed
Mammography	/ /	Flexible Sigmoidoscopy	/ /
Pap Smear for Women Over Age 18	/ /	Hemoccult Stool Analysis	/ /
Human Papillomavirus Vaccination (HPV)	/ /	EKG/ECG	/ /
Prostate Specific Antigen (PSA)	/ /	Whole Body Skin Cancer Screening	/ /
Colonoscopy	/ /	CA125 Blood Test	/ /
CT Colonoscopy	/ /	Doppler Screening for Cartoids	/ /

Some select policies include coverage for two additional services. If your policy includes these two additional services, please complete below if you are claiming either of the following services.

Routine SERVICE	Date Completed	Routine SERVICE	Date Completed
Biometric Screening	/ /	Genetic Testing (BRCA1 or BRCA2)	/ /

Section C: Only complete this section if, as a result of one of the above covered routine services (excluding biometric screening), you required and received a follow-up diagnostic test. Please include the date of the initial routine test, the date of the follow-up diagnostic test and the name of the diagnostic test.

_____/_____/_____ _____/_____/_____ _____
Date of routine test *Date of follow up diagnostic test* *Name of follow up diagnostic test completed*

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Section D: Please sign, print your name and date below to certify to the accuracy of information provided.

_____ _____ _____/_____/_____
Policy Owner Signature Print Name Date

Section E: Only have this section completed if the claimed testing was completed as part of a wellness clinic sponsored by your employer and you have no documentation of the date and type of test provided. To be completed by the Medical Professional who completed the testing.

_____ _____ _____/_____/_____
Signature of Medical Professional Print Name Date

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Electronic Communication: If you choose 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 email communication between you and us.

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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Insured Statement of Claim – 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 may 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 PO 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 Signature ***Date***

_____ _____

Printed Name ***Social Security Number***

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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 benefits under your policy. Note: Policy Owner and Claimant must give permission for disclosure of their information to each other, if applicable.

Policy Owner Name:_____

Claimant Name: _____

Policy Number(s): _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

□ **My Agent: (Name of Agent)** _____

□ All information (all policy and claim information)

□ Only the following information*: _____

□ **My Employer: (Name of Agent)** _____

□ All information (all policy 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 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 **RiderClaims@trustmarkins.com**. This authorization is valid for 24 months. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____
Signature of Policy Owner | Signature of Claimant (If someone other than the Policy Owner)

_____ _____
Printed Name | Printed Name

_____/_____/_____ _____/_____/_____
Date | Date