Group Life Death Benefit Claim

For Claims Customer Service: **Phone:** 866-813-7192
For Claims Submission: **Fax:** 508-718-2411 **Email:** GroupLifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Claim Submission Instructions and Supporting Documentation

Please ensure you complete every question on this claim form. Please note claim forms and all required supporting documents should be filed within 30 days of death claim notification. Please note incomplete or illegible answers may result in a delay in processing benefits

Please keep a copy of all parts of this form and any supporting documentation for your records.

The following information must be supplied:

- **A Certified copy of the Death Certificate** – Death Certificate should indicate the manner and cause of death
- **Statement of Beneficiary –** *To be completed by all person(s) to whom the benefits are payable.*
  - ***If more than one Beneficiary*** – all may join in one statement or a separate form will be furnished for each if desired.
  - ***If Beneficiary is estate, executor(s) or administrator(s)*** –the statement should be completed by the executor or administrator, a certified copy of whose appointment and qualifications must be furnished.
  - ***If Beneficiary is minor or a mentally incompetent person*** – the statement should be completed by the guardian with proof of financial guardianship provided. If payable to a minor, a copy of the minor's birth certificate and Social Security card must also be supplied.
  - ***If there is an Assignment*** – such as the certificate benefits have been assigned to a funeral home or funding company, enclose a notarized copy of the assignment.
  - ***If Beneficiary is a Trust*** – information should be completed on behalf of the Trust by the designated Trustee(s). If any Trust fails to make claim for the certificate proceeds within 12 months after the Company is notified of the insured's death, or if the company receives satisfactory evidence that the Trust is not in effect, payment will be made as if the Trust was not named as Beneficiary. Please provide a complete copy of the Declaration of Trust.
  - ***If cause of death is not from natural causes*** – If the cause of death is due to an accident, suicide, overdose, or homicide, please enclose a copy of any police report, accident report, autopsy report, or toxicology report.
- **Affidavit for Surviving Spouse or Next of Kin –** This section must be completed by surviving spouse, next of kin, executor or administrator of the estate.
- **E-Sign Disclosure and Consent Notice** – *This section of the claim form is not required, but completing it will provide better and faster communication with you or anyone you designate. Complete if you would like claim communication by text or email, including text alerts for payments released. It should be completed by each Beneficiary, Executor and/or Administrator who would like to receive communication. If not completed, please note default communication will be written and sent via USPS.*
- **State Required Fraud Language –** These sections of the claim form provide important information about the laws in each state.
- **Disclosure Authorization -** *To be completed by 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 regarding the relationship of the person completing it (e.g. executorship paperwork) should be included.
- **Statement of Primary Care Physician –** This form should be completed by the decedent's Primary Care Physician.
- **Ex-Spouse of Insured** – **Divorce information if Ex-Spouse is Beneficiary**–Under certain circumstances, state law provides for automatic revocation of spouse as Beneficiary upon divorce. Copies of the Petition for Divorce, any property settlement agreements, and the final Divorce Decree must be submitted if the ex-spouse is named as Beneficiary.

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Statement by Beneficiary – Insured's Information

Decedent's Full Name: _____ Certificate #:_____

Decedent's DOB: _____ Decedent's SSN: _____

Spouse's Full Name: _____

Decedent's Address:

_____

Street City State Zip Code

Marital status at time of death:

□ Single □ Married □ Domestic Partner □ Widowed □ Divorced (If divorced, provide dissolution paperwork).

Date of death: _____Place of death: _____

Cause of death: _____

Was decedent employed prior to their death? □ Yes □ No

If no, when was last day worked? _____

Was decedent confined to a hospital at time of death? □ Yes □ No

If yes, please provide business name and address.

_____

Over the past three years, how often did the deceased smoke cigarettes or use other tobacco products?

□ Daily □ Weekly □ Other □ Never □ I don't know

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

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Statement by Beneficiary – Insured's Information (continued)

Names of any medications prescribed for deceased within the five years preceding death		
Medication Name	**Reason Prescribed**	**When First Prescribed**

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

Beneficiary's Full Name:_____ DOB: _____

Social Security #:_____ Phone#: _____

Beneficiary's Address:_____

Street City State Zip Code

Email: _____

Relationship to Insured: _____

□ Spouse □ Domestic Partner □ Child □ Parent □ Other _____

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:

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. In New York, civil penalty shall not exceed five thousand dollars and the stated value of the claim for each such violation.

I declare that all of the above statements on this claim form and attached documentation are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices contained inthis form.

Beneficiary's Signature:_____ Date: _____

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Affidavit of Surviving Spouse or Next of Kin

State of)
) SS:
County of)

I,_____being duly sworn according to law, declare that I reside at:
(First, middle, last name)

_____, _____and that on
(Street address) *(City, State)*

_____, _____, who made no will, had permanent legal
(Date) *(Name of the Deceased)*

residence at _____.
(Street address) *(City, State)*

I am the ☐ widow, ☐ widower, ☐ child, ☐ father, ☐ mother, ☐ other and as such am entitled to receive the
(Check relationship)

decedent's estate under the laws of _____.
(Name of U.S. state where decedent last had legal permanent residence)

NAMES OF SURVIVORS, IN ORDER OF KINSHIP

Please insert the names of living relatives in the following order of relationship: surviving spouse, children, father and/or mother, brothers and/or sisters:

Name	Date/Place of Birth	Address	Relationship

_____
(Signature of Affiant)

Subscribed and sworn (or affirmed to) before me by _____at

_____on _____.

(Seal)

_____ _____
(Signature of Notary Public) *(Name of Notary Public)*

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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 #: _____

☐ Email Only - Please confirm 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 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.

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.

We may request that you respond to an email to demonstrate you are able to receive these Communications.

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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, P.O. Box 2906, Clinton, IA 52733." 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, P.O. Box 2906 Clinton, IA 52733,." 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, P.O. Box 2906, Clinton, IA 52733.

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 can 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.

_____ _____
Beneficiary Signature ***Date Signed***

_____
Printed Name

Address: _____
Street City State Zip Code

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State Required Fraud Language

Fraud Statement for the states of Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma, 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 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 the 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: Any person who, with a purpose to injure, defraud or deceive an 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 in RSA 638:20.

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 New York: 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. In New York, civil penalty shall not exceed five thousand dollars and the stated value of the claim for each such violation.

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 the 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

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

Insured's name (Patient) (*Please Print***):**_____**Last 4 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.

II 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.

Signature of Next of Kin or Executor of the Estate: _____ Date Signed: _____

Printed Name: _____

Relationship to Insured: _____

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Statement of Primary Care Physician *(To be completed by the decedent's Primary Care Physician)*. **In addition, we will require medical records for the last 3 years of visits.**

Patient's Name: _____ **Patient DOB**: _____

Prior to passing away, how long have you treated the deceased? _____

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	Dates of Treatment	Duration of Treatment

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

Physician Name	Full Address	Phone	Disease or Condition

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

Medication Name	Reason Prescribed	Start Date of Medication

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.
The above statements are true and complete to the best of my knowledge and belief.

Physician's Name (please print)_____Specialty_____

Phone:_____ Fax: _____ Email: _____

Address: _____
Street City State Zip Code

Signature_____ Date _____