Trustmark Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Wellness/Health Screening Claim Form

Claims Customer Service: Phone: 877-201-9373 **Claims Submission: Fax:** 508-471-3208 **or Email:** Riderclaims@trustmarkins.com

IMPORTANT NOTICE: In order for us to consider any benefits, you must attach copies of Outpatient Bills / Invoices or Explanation of Benefits to support the testing you had completed. Please complete a SEPARATE FORM FOR EACH CLAIM you are submitting for yourself or for each family member, for each date of service or test. We will only consider one (1) test per claim form. Submission of multiple dates or tests on one claim form will not be considered, except for the most recent date/test.

- ⇨ **Section A & B -** Complete both sections, sign and return to us for consideration of benefits. All questions must be answered in full. **Incomplete or illegible answers may result in delay of benefit consideration**. Please keep a copy of all parts of this form and any attachments for your records.
- ⇨ **Section C –** To be completed if you received your testing through an Employer Sponsored Clinic. Complete Section A & B as well.
- ⇨ **State Required Fraud Language:** Attached for your information

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

Section B – Claimant 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 covered person had completed.

Name of tested person: _____ 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 Wellness or Health Screening Rider.

Please note which test you had completed by providing the date it was completed in the section below. As noted above, a separate claim form is needed for each date / test for each person in order for claim to be considered.

TEST OR WELLNESS	Date Completed	TEST OR WELLNESS	Date Completed
Immunization Please indicate for what:	/ /	Serum cholesterol test to determine levels of HDL and LDL	/ /
Routine Physicals	/ /	Bone marrow testing	/ /
Low Dose Mammography	/ /	Breast ultrasound	/ /
Pap Smear for women over age 18	/ /	CA 15-3 (blood test for breast cancer)	/ /
Flexible Sigmoidoscopy	/ /	CA125 (blood test for ovarian cancer)	/ /
Hemoccult Stool Specimen	/ /	CEA (blood test for colon cancer)	/ /
Colonoscopy	/ /	Chest X-ray	/ /
Prostate Specific Antigen	/ /	Serum Protein Electrophoresis (blood test for myeloma)	/ /
Stress test on a bicycle or treadmill	/ /	Thermography	/ /
Fasting blood glucose test	/ /		
Blood test for triglycerides	/ /		

Section C

If the above testing was completed as part of a WELLNESS CLINIC sponsored through your employer, Section C below can be completed by the medical professional providing the service in lieu of providing copies of your billing or invoices.

The insured/patient listed below has received the service dated above.

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

_____ _____ _____/_____/_____
Employee Signature: Print Name: Date:

PLEASE EITHER FAX TO: 508-471-3208 OR SCAN TO: **Riderclaims@Trustmarkins.com**

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.

Trustmark Insurance, P.O. Box 60676, Worcester, MA 01606 ☎ Phone: 877-201-9373 🖷 Fax: 508-471-3208

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, 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 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 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.