

**TRUSTMARK
INSURANCE COMPANY**

Group Short Term Disability Claim Form

PART A STATEMENT OF THE COVERED EMPLOYEE

Full Name (Please Print)	Home Telephone No. ()	Date of Birth	Social Security No. - -
Address (number and street)		(City)	(State) (Zip)
Name of Employer		Occupation	Date Employed
Is this Claim the result of a work related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Claim due to Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", Date of Accident	
Where did Accident occur? How?			

AUTHORIZATION - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or consumer reporting agency, or employer having any records or information pertaining to all medical history, mental or physical condition, evaluation, diagnosis, treatment or prognosis, specifically to include psychiatric, drug or alcohol abuse treatment of me to give to TRUSTMARK INSURANCE COMPANY, Lake Forest, Illinois or its legal representatives, any and all such information. I further acknowledge that the information obtained by use of this Authorization will be used by TRUSTMARK INSURANCE to determine my eligibility for benefits. I understand that I may request a copy of this Authorization. I further agree that a photostatic copy of this Authorization shall be as valid as the original, and that such Authorization shall be valid for two years from the date shown below.

Employee Signature _____ Date _____

PART B TO BE COMPLETED AND SIGNED BY THE EMPLOYER

Employer _____

Occupation with brief description of job _____

Has Employment been terminated? Yes No If Yes, give date _____

Date Employee last worked _____ Weekly Wage _____

Date Employee Returned to work _____

_____ (Authorized Employer Representative) _____ Title _____ (Date Signed)

ANY PERSON WHO KNOWINGLY FILES A CLAIM CONTAINING FALSE, MISLEADING OR INCOMPLETE INFORMATION MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

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**BOTH SIDES MUST BE COMPLETED
REMINDER**

PART C

**SHORT TERM DISABILITY
ATTENDING PHYSICIAN'S STATEMENT**

Employee name _____

Diagnosis and concurrent conditions _____

Dates of Services Office

Hospital

Surgery (describe) _____

Date symptoms first appeared or accident happened. _____

Date patient first consulted you for this condition. _____

Limitations and restrictions: _____

Patient was continuously totally disabled (Unable to work) From _____ To _____

If still disabled, date patient should be able to return to work. _____

Date Physician's Name (Print) Signature Degree

Street Address City or Town State or Province Zip Code Telephone No.

V314-7917

BOTH SIDES MUST BE COMPLETED

In some states, we are required to inform you that: any 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, may be committing a fraudulent insurance act, which is a crime.

In Florida we are required to inform you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

In California and New Jersey we are required to inform you that: any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

In Minnesota we are required to inform you that: a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.