



Underwritten by Trustmark Insurance Company

Initial Waiver of Premium Claim

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310

Email: Claims@ULAflac.com

Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Section A – Insured Information

Policy / Certificate #: _____

Name: _____ DOB: ___/___/___ SSN: _____

Address: _____
Street City State Zip Code

Phone # _____ Home Cell Work E-Mail Address: _____

Employer Name & Address : _____
Name Address City State Zip Code

Date Employed: ___/___/___ Occupation _____

Principal Duties: _____

Doctors Consulted:

Name Address Dates

Name Address Dates

Name Address Dates

Name of Hospital: _____ Date Admitted: ___/___/___ Date Discharged: ___/___/___

Describe nature of illness or injury: _____

If **Illness**, what date did you first notice the illness? ___/___/___

If **Accident**, on what date? ___/___/___ Where you at work? Yes No

How did it happen? _____

Date & time you stopped working: ___/___/___ _____ AM PM

Dates you were continuously confined to your home: From: ___/___/___ To: ___/___/___

Date & time you resumed working: ___/___/___ _____ AM PM

If unable to resume work at present, about what date should you be well enough to resume work? ___/___/___

Are you making claim with any other company? Yes No

If yes, please provide:

Company Name Amount of Policy

Company Name Amount of Policy

***** Complete & Sign Disclosure Authorization Portion of Claim Form *****



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Section B – Employer Statement

This statement must be completed by the supervisor or timekeeper of the employer. If the insured is self-employed, the insured will complete the following statement giving all the details.

Name of Employee: _____ Policy #: _____

Occupation of the insured at the time of disability: _____

Employed how many days per week? _____

Average monthly earnings? \$ _____

Date & time employee last worked: ___/___/___ AM PM

Date & time employee returned to work: ___/___/___ AM PM

Occupation of which the insured returned?: _____

Company Name: _____

Address: _____
Street City State Zip Code

Printed name _____ Official Title _____

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

Signature _____ Date ___/___/___



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Section C – Attending Physician’s Statement *(To be completed by the Attending Physician)*

Name of Patient: _____ Patient I.D. Number: _____

1. History

When did symptoms 1st appear or accident happen? ___/___/___ Date patient ceased work because of disability? ___/___/___

Has patient ever had same or similar condition? Yes No

If yes, when and describe: _____

Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown

Names & addresses of other treating physicians:

Name _____ Address _____

Name _____ Address _____

2. Diagnosis (including any complications)

Diagnosis: _____

Subjective Symptoms: _____

Objective findings (including current Xrays, EKGs, Lab Data and any clinical findings):

3. Dates of Treatment

Date of 1st visit: ___/___/___ Date of last visit: ___/___/___ Frequency: Weekly Monthly Other _____

4. Nature of Treatment (including Surgery & medications prescribed, if any)

Treatment: _____

Will treatment substantially improve function and employability? Yes No

5. Progress

Has patient: Recovered Improved Unchanged Retrogressed

Is patient: Ambulatory House Confined Bed Confined

6. Physical Impairment (Please check one)

Class 1 - No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)

Class 2 - Slight limitation of functional capacity; capable of light manual activity. (15-30%)

Class 3 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)

Class 4 - Marked limitation. (60-70%)

Class 5 - Severe limitation of functional capacity.

Remarks: _____

7. Mental / Nervous Impairment (if applicable)

Class 1 - Patient is able to function under stress & engage in interpersonal relations (no limitations).

Class 2 - Patient is able to function in most stress situations & engage in most interpersonal relations (slight limitations).

Class 3 - Patient is able to engage in only limited stress situations & engage in only limited interpersonal relations (moderate limitations).

Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).

Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

Remarks: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No



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8. Prognosis

	Patient's Job	Any Other Work
Is the patient now totally disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you expect a fundamental or marked change in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when will patient recover sufficiently to perform duties?	<input type="checkbox"/> 1 Mo <input type="checkbox"/> 1-3 Mos <input type="checkbox"/> 3-6 Mos <input type="checkbox"/> Never ___/___/___	<input type="checkbox"/> 1 Mo <input type="checkbox"/> 1-3 Mos <input type="checkbox"/> 3-6 Mos <input type="checkbox"/> Never ___/___/___
If no, please explain:		
Date released to work:	___/___/___	___/___/___

9. Rehabilitation

	Patient's Job	Any Other Work
Is the patient a suitable candidate for trial employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when could trial employment commence?	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time ___/___/___	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time ___/___/___
If yes, what training will patient require?		
If no, please explain:		

10. Remarks

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 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 Arkansas, 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 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 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 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.



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DISCLOSURE AUTHORIZATION

Insured's name (Please print): _____

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 other 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. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the 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 the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. 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.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

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.

Residents of Florida – Any person who knowing and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of NY – 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 or each such violation.

Date ___/___/___

Signature: _____

Date of Birth ___/___/___

Relationship, if other than insured: _____



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Insured Statement of Claim – Communication

1. 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 in writing.

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.

Authorization

I may revoke or update this authorization in writing at any time or by email to Claims@ULAflac.com.

Trustmark Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. 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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Insured Statement of Claim – Communication *(Continued)*

2. Third Party Communication Authorization

Please complete this authorization if you would like us to discuss, to release, or to provide information to a family member, friend, or other third party such as your agent or employer.

My Spouse or Partner: (Name) _____

All Information (All policy and claim information)

All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

My Family Member: (Name and Relationship) _____

All Information (All policy and claim information)

All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

Other Third Party: **My Agent:** Yes **My Employer:** Yes

Or Name a Specific Third Party (Name and Relationship) _____

All Information (All policy and claim information)

All Information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

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 regulations governing the privacy of health information relative to my condition.

Authorization

I may revoke or update this authorization in writing at any time or by email to Claims@ULAflac.com.

Trustmark Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

Policy Owner (Or Policy Owner's Personal Representative's Signature)

Date

Printed Name

Social Security Number