Permanent Waiver of Premium Claim NY

Underwritten by Trustmark Life Insurance Company of New York

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: ____/____/____

Address: _____
Street City State Zip Code

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

Describe nature of sickness or injury: _____

_____

_____

On what date did you become totally disabled? ___/___/___

Are you continuously confined to your home? ❑Yes ❑ No

If yes, please provide dates: From: ___/___/___ To: ___/___/___

What is the date of your last visit to your doctor? ___/___/___

Have you considered rehabilitation for other forms of suitable, gainful employment or been in contact with either your state ***Division of Vocational Rehabilitation*** or a similar private Agency? ❑Yes ❑ No

If yes, please explain: _____

_____

_____

Are you able to perform any duties or work for profit or hire? ❑Yes ❑ No

When do you expect to resume work? ___/___/___

Insured's name (please print)_____

Signature_____ Date ____/____/____

*****Please complete & sign *DISCLOSURE AUTHORIZATION* section of form*****

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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 Life Insurance Company of New York 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 Life Insurance Company of New York 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 Life Insurance Company of New York. I AGREE the information obtained with this Authorization may be used by Trustmark Life Insurance Company of New York 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 Life Insurance Company of New York and affiliates to report to ICS, any dates of past or present claims filed by me.

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 Life Insurance Company of New York 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 Life Insurance Company of New York 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 Life Insurance Company of New York 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***