Aflac
Underwritten by Trustmark Insurance Company

Accelerated Death Benefit 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: _____

Occupation _____

Current Illness _____ Date of Diagnosis: ____/____/____

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

Section B – Attending Physician's Statement *(To be completed by the Attending Physician)*

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

Please state diagnosis: _____

Describe nature & cause of injury or condition: _____

Date of symptoms first occurred: ____/____/____ ICD-10 Code: _____

Has patient had same or similar condition? ❑ Yes ❑ No If yes, when? ____/____/____

If no, what are the contributing factors?_____

List all dates of treatment: _____

List all prescribed treatment: _____

List present medications: _____

Is patient hospitalized? ❑ Yes ❑ No If yes, give dates: _____

Hospital Name(s): _____

Hospital Address: _____
Street City State Zip Code

Phone #_____

Name of Referring Physician (if applicable):_____

Address: _____
Street City State Zip Code

Prognosis: _____

After a thorough, extensive medical review, I have concluded that _____ is terminally ill and is anticipated to only survive the next _____ months.

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

The following disclosure is made pursuant to the Fair Credit Reporting Act:

Please be notified that, as a result of our regular claims investigation procedures, an investigative consumer report may be prepared, whereby information received from third parties is obtained from an independent inspection company. You have the right to make a written request within a reasonable period of time to receive detailed information about the nature and scope of this investigation.

Authorization:
I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, Veterans Administration or government agency to furnish all information and copies of records regarding health care or treatment provided me, including, but not limited to, admitting records, hospital records, test records, finding and diagnostics. Such information and records shall be provided to a representative of the Claim Department of Trustmark. The information obtained by this authorization is for use solely to determine my eligibility for insurance benefits. This authorization includes information about drugs, alcoholism or mental illness.

I authorize my present or past employer(s) to supply information covering the status of my employment, job duties, days absent from work and training provided. This information may be provided to a representative of Trustmark and is to be used solely to determine my eligibility for insurance benefits. Any information obtained will not be released by Trustmark to any person or organization.

I further authorize Trustmark to release all copies of medical records collected during its investigation to a second physician (and third, if required). I further authorize this statement to be copied and the copy utilized as if it were an original. I understand that upon request I have a right to obtain a copy of this authorization. I understand this authorization will remain valid for one year from this date.

I understand that failure to sign this authorization may delay the payment of my claim.

Owner's Signature: _____ Date Signed: ___/___/___

Signatures Required

I have read the statement on this form and concur with them. I am of sound mind and have advised my beneficiaries, the executor of my estate, and my attorney of my action and have instructed that I alone am responsible for seeking this benefit. If the Accelerated Death Benefit is advanced to me, my executor, assignees, beneficiaries and I agree to hold Trustmark harmless and free from all liability for having advanced this death benefit.

Insured/Claimant Signature: _____ Date Signed: ___/___/___

Spouse Signature: _____ Date Signed: ___/___/___
(If a Community Property state. I hereby forever waive all community property right and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner).

Owner Signature: _____ Date Signed: ___/___/___
(if other than insured)

Joint Owner Signature: _____ Date Signed: ___/___/___
(if applicable)

Irrevocable Beneficiary Signature: _____ Date Signed: ___/___/___
(if applicable, I hereby forever waive all rights and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner.))

Notarized Signature: _____ Date Signed: ___/___/___

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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***