Convalescent Care Benefit 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

Instructions: In order to provide prompt service to your request for benefits under the Convalescent Care Benefit Rider, complete form as follows:

- ***Section A – Statement of the Insured*** in its entirety
- Sign and Date the ***Disclosure Authorization***
- Have your physician complete the ***Attending Physician's Statement***

Completed claim form should be returned to: Trustmark Life Insurance Company of New York, PO Box 60676, Worcester, MA 01606
Benefit payments may only be made if the payments are subject to favorable tax treatment by the Federal Government. When determining whether the benefit payments will receive favorable tax treatment, the payment of benefits from all insurance policies must be considered.

Section A – Statement of the Insured

Policy / Certificate #: _____

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____
Street City State Zip Code

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

Employer/Supervisor: _____
Name Address Phone

Date Last Worked: ____/____/____

Benefit(s) applied for: ❑ Long Term Care Facility Benefit ❑ Assisted Living Benefit ❑ Home Health Benefit
❑ Adult Day Care Benefit

Are you covered by other insurance policies that pay similar benefits? ❑ Yes ❑ No
If yes, is policy tax-qualified? ❑ Yes ❑ No

Name & Address of Carrier: _____
Name Address

Benefit Amount: _____ ❑ Per Day ❑ Per Month

Licensed Health Care Providers Consulted Other Than Certifying Physician, For Present Condition:

_____
Name Address Phone Dates

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

Date of Accident/ Illness: ____/____/____ Description of Accident / Illness: _____

Is this a work-related injury or illness? ❑ Yes ❑ No Place of Accident: _____

Nature & Extent of Injury or Illness: _____ Date of 1st Treatment: ___/___/___

Have you had any other medical attention in the past five (5) years? ❑ Yes ❑ No If yes, please complete following:

_____
Doctor's Name Address Phone

_____
Diagnosis Dates of Treatment

What activities of Daily Living are you currently unable to perform without assistance? (*Please check all that apply*)

❑ Bathing ❑ Toileting ❑ Dressing ❑ Walking ❑ Eating ❑ Taking Medication ❑ Getting In & Out of Bed

If any checked above, please explain: _____

If patient / insured is incompetent, please provide name, address, and ***notarized*** papers for Guardian, Conservator, Power of Attorney, or Trustee who is responsible for financial affairs.

Name & Address: _____
Name Address

Convalescent Care Benefit 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 – Statement of the Insured (Continued)

Complete for Home Health Care or Adult Day Care Only:

Name & Address of Agency Providing Home Health Care:

_____
Name Address Date of Service

Physician Who Is Certifying Care:

_____
Name Address Date of Service

Complete for all types of care or benefits:

AUTHORIZATION — I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, OR OTHER ORGANIZATIONS, INSTITUTION OR PERSON WHICH MAY HAVE INFORMATION PERTINENT TO MY CLAIM, 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, COMMUNICABLE OR INFECTIOUS DISEASES, INCLUDING AIDS AND ANY OTHER NON-MEDICAL INFORMATION OF ME TO GIVE TO TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK 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 LIFE INSURANCE COMPANY OF NEW YORK 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 ONE YEAR FROM THE DATE SHOWN BELOW.

By signing this claim form you declare that your application for this benefit is voluntary and without coercion on the part of any third party.
No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

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, 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 for each such violation.

Insured Signature_____ Date ____/____/____

Date of Birth: ___/___/___ Relationship, if other than insured: _____

Convalescent Care Benefit 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 B – Attending Physician's Statement *(To be completed by the Attending Physician)*

Your prompt completion of all items on this form will help us help your patient

Name of Patient: _____ Age: _____

Date of illness (1st Symptom) or injury (accident): ____/____/____ Date 1st consulted you for this condition: ____/____/____

If patient has had same or similar illness or injury, list dates & diagnosis: _____

Name & Address of Referring Physician or Other Sources (Public Health Agency):

_____
Name Street City State Zip Code

Has patient any chronic or constitutional disease, physical defect, or deformity? ❑ Yes ❑ No

If yes, describe:_____

Patient's Diagnosis & ICD-Code: _____

The patient needs assistance with the following (please check all that apply):

❑ Bathing ❑ Toileting ❑ Dressing ❑ Walking ❑ Eating ❑ Taking Medication ❑ Getting In & Out of Bed

Cognitive Impairment		**Good**	**Fair**	**Poor**
Short Term Memory		☐	☐	☐
Long Term Memory		☐	☐	☐
Understands & Follows Simple Directions		☐	☐	☐
Orientation To:	Time	☐	☐	☐
	Place	☐	☐	☐
	Person	☐	☐	☐

Does patient suffer from any mental, psychoneurotic or personality disorder without demonstrable organic disease? ❑ Yes ❑ No

If yes, describe:_____

Type of Service Receiving				
Receiving	**Type of Agency/ Facility**	**Name & Address of Agency / Facility**	**Phone #**	**License #**
❑ Yes	Home/Health Care			
❑ Yes	Adult Care Center			
❑ Yes	Long Term Care			

If yes to either Long Term Care, please provide the following:

Tax ID of Facility:	Licensed By State? ❑ Yes ❑ No	License #:
Licensed as what? (Please check)	❑ Skilled Nursing Care ❑ Intermediate Nursing Care ❑ Residential ❑ Other (Please specify):	

What is your prognosis for recovery and/or cessation of treatment? _____

Expected length of confinement or service? From: ____/____/____ To: ____/____/____

Physician's name (please print)_____ Phone: _____-_____-_____

Address: _____
Street City State Zip Code

I certify that the above Confinement, Care, or Service is medically necessary.

Signature_____ Date ____/____/____

Convalescent Care Benefit 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

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***

Convalescent Care Benefit 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

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***