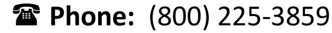
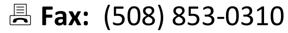
Accelerated Death Benefit Claim - NY

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

- Complete *Section A – Insured Information* of this claim form.
- The Policy Owner must sign and date the *authorization*.
- Have the physician complete the *Section B – Attending Physician's Statement (I).*
- The Insured / Claimant, Spouse and/or Owner must complete the *Signatures Required* portion of the claim form.

Underwritten by Trustmark Life Insurance Company of New York

Accelerated Death Benefit Claim - NY

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 #: ________________

Insured Name: ____________________________________ DOB: ____/____/____ SSN: ______________________

Address: ____
Street City State Zip Code

Phone #________________________ ❑Home ❑Cell ❑Work E-Mail Address: ____

Occupation ____

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

Physician's Name ____

Physician's Address ____

If hospitalized within the last five (5) years, list hospitals

____
Hospital Address Date Admitted

Employer's Name & Address____

Note: Accelerated Death Benefit not available if policy is assigned: proper release documents should accompany this form.

If policy is assigned, give name and address of assignee:

____
Assignee Name Assignee Address Amount of Assignee Claim

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 Life Insurance Company of New York. The information obtained by this authorization is for use solely to determine my eligibility for insurance benefits. This authorization includes information about 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 Life Insurance Company of New York and is to be used solely to determine my eligibility for insurance benefits. Any information obtained will not be released by Trustmark Life Insurance Company of New York to any person or organization.

I further authorize Trustmark Life Insurance Company of New York 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.

Insured's Signature: ____ Date Signed: ___/___/___

Underwritten by Trustmark Life Insurance Company of New York

Accelerated Death Benefit Claim - NY

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 (I) *(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 ____/____/____

Physician (II)

I have reviewed ____case and medical records.

I concur with Dr. ____ on the prognosis.

A copy of my medical evaluation is attached.

Physician's name (please print)____ Specialty______________________________

Address: ____
Street City State Zip Code

Signature:____ Date ____/____/____

Accelerated Death Benefit Claim - NY

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

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.

New York regulation requires Trustmark Life Insurance Company of New York to provide you with the following notices and statements: Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse and dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.

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.

Within 5 days of receiving your request that you may want to claim the accelerated death benefit, Trustmark Life Insurance Company of New York is required to provide you with: 1) a numerical computation of the amount of the death benefit You requested for acceleration, and the amount to be paid in cash; 2) the amount of your death benefit if you chose not to accelerate it; 3) an illustration demonstrating the effect of the accelerated death benefit requested on the policy's face amount, death benefit, premium payments, accumulation account, cash value, loan balance, and partial withdrawals as provided under the terms of the policy. Trustmark Life Insurance Company of New York is prohibited from paying accelerated death benefits to you for 14 days from the date on which this information is transmitted to you in writing. Trustmark Life Insurance Company of New York reserves the right to charge an administrative fee of up to $250.

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 for each such violation.

New York Regulation requires that this claim form must be completed and signed by Policyowner within 30 days from the date Trustmark Life Insurance Company of New York transmitted this claim form.

Date of Transmittal: ____________________

Return completed claim form to: Trustmark Life Insurance Company of New York, PO Box 60676, Worcester, MA 01606

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:** ___/___/___

Accelerated Death Benefit Claim - NY

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***

Accelerated Death Benefit Claim - NY

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*