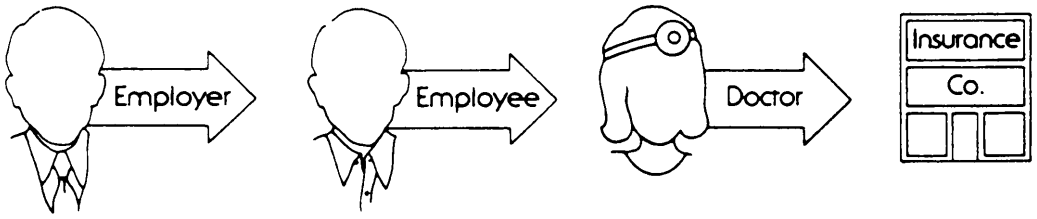
Trustmark
LIFE INSURANCE COMPANY

P.O. Box 7948 • Lake Forest, IL 60045-7948
Phone 1-800-307-3929 • Fax (847)615-3866

Proof of Loss of Limb(s)
or
Sight Statements



NOTICE OF CLAIM — Instructions

A. Employer

1. Complete Part III — Statement of Employer.
2. Forward claim statement to your employee.

B. Employee

1. Complete Part I — Statement of Insured
2. Sign Authorization to Disclose/Release or Obtain Medical Records.
3. Have Eyewitness complete Part II. If no Eyewitness was present at the time of the accident, Part II should be completed by the first person to reach you immediately after the accident.
4. Forward Statement of Attending Physician to your treating physician.

C. Physician

Complete Part IV — Statement of Attending Physician.

All portions of this claim form must be completed to avoid undue delay in processing the claimant's request for benefits. Once the claim form is completed, please forward to the address listed above.

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PROOF OF LOSS OF LIMB(S) OR SIGHT STATEMENTS

PART I — STATEMENT OF INSURED

(1) NAME (AS APPEARS IN POLICY)	(2) DATE OF BIRTH	(3) SOCIAL SECURITY NO.
(4) HOME ADDRESS - NO. AND STREET CITY STATE		(5) POLICY NUMBER
(6) NAME AND ADDRESS OF EMPLOYER	(7) YOUR OCCUPATION WHEN INJURED OR ON THE LAST DAY YOU WORKED.	
(8) DATE OF ACCIDENT	(9) TIME OF ACCIDENT _____ ☐ AM ☐ PM	(10) WHERE DID ACCIDENT HAPPEN?
(11) HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)		
(12) WHAT INJURIES DID YOU RECEIVE?		
(13) WHEN DID YOU STOP WORKING? DATE _____ HOUR _____ ☐ AM ☐ PM	(14) HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	(15) DATE OF RETURN TO WORK
(16) WHEN DID YOU FIRST CONSULT A PHYSICIAN FOR THIS INJURY? DATE _____ PHYSICIAN'S NAME AND ADDRESS:		
(17) NAME AND ADDRESS OF ANY OTHER PHYSICIAN(S) CONSULTED FOR THIS INJURY:		
(18) WHEN DID TOTAL LOSS OF LIMB(S) OR SIGHT OCCUR?	(19) DID YOU HAVE ANY PREVIOUS INJURY, DEFECT OR DISEASE WHICH AFFECTED THE INJURED LIMB(S) OR EYE? ☐ YES ☐ NO	
(20) IF HOSPITALIZED - NAME OF HOSPITAL	DATE ADMITTED DATE _____ HOUR _____ ☐ AM ☐ PM	DATE DISCHARGED DATE _____ HOUR _____ ☐ AM ☐ PM
(21) ARE YOU MAKING CLAIM AGAINST ANY OTHER COMPANY, ASSOCIATION OR LODGE FOR THIS LOSS? ☐ YES ☐ NO IF SO, GIVE NAME OF ORGANIZATION		(22) HAVE YOU MADE ANY CLAIM AGAINST THIS COMPANY BEFORE? ☐ YES ☐ NO

In New York we are required to tell you that: 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 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.

DATE _____ **INSURED'S SIGNATURE** _____

PART II - STATEMENT OF EYEWITNESS

IF NO EYEWITNESS PRESENT, THIS PART SHOULD BE COMPLETED BY THE FIRST PERSON TO REACH CLAIMANT IMMEDIATELY AFTER THE ACCIDENT

(1) WERE YOU PRESENT WHEN THE ACCIDENT OCCURRED?

☐ YES ☐ NO

(2) DID YOU WITNESS THE ACCIDENT?

☐ YES ☐ NO

(3) ARE YOU PERSONALLY ACQUAINTED WITH THE INSURED?

☐ YES ☐ NO

IF YES, CHECK THE FOLLOWING ☐ FELLOW WORKER ☐ FRIEND ☐ RELATIVE

(4) WHERE WAS THE CLAIMANT WHEN INJURED AND WHAT WAS HE DOING?

(5) DESCRIBE THE ACCIDENT FULLY, GIVING ALL THE PARTICULARS:

DATE _____

SIGNED _____

ADDRESS _____

TELEPHONE _____
(Area) (No.)

_____
(City) (State) (Zip)

PART III - STATEMENT OF EMPLOYER

(1) NAME OF EMPLOYEE

(2) WHAT WAS HIS OCCUPATION ON THE DAY HE WAS INJURED OR ON LAST DAY HE WORKED?

(3) IS DISABILITY A RESULT OF EMPLOYMENT?
☐ YES ☐ NO
IF SO, PLEASE STATE FULLY HOW THE EMPLOYEE WAS HURT AND WHAT HE WAS DOING AT THAT TIME:

(4) DID ACCIDENT HAPPEN AWAY FROM WORK?
☐ YES ☐ NO
IF SO, PLEASE GIVE DETAILS AS REPORTED TO YOU:

(5) WHEN DID INJURY HAPPEN?
DATE _____ HOUR _____ ☐ AM ☐ PM

(6) WHEN DID THE EMPLOYEE STOP WORKING?
DATE _____ HOUR _____ ☐ AM ☐ PM

(7) HAS EMPLOYEE RETURNED TO WORK? IF SO, WHEN:
☐ YES ☐ NO DATE _____

(8) WAS THERE ANY EVIDENCE OF THE EMPLOYEE BEING UNDER THE INFLUENCE OF INTOXICANTS OR DRUGS PRIOR TO OR AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

EMPLOYER _____ **ADDRESS** _____
ST. NO. CITY STATE

SIGNED _____ **TITLE** _____ **TELEPHONE** _____ DATE _____
(AREA) (NO.)

PART IV - STATEMENT OF ATTENDING PHYSICIAN

(1) NAME OF PATIENT	(2) WHEN DID YOU FIRST ATTEND PATIENT FOR THIS INJURY? DATE _____
(3) WHEN DO YOU UNDERSTAND THE INJURY WAS RECEIVED? DATE _____ HOUR _____ ☐ AM ☐ PM	(4) WHERE DID ACCIDENT HAPPEN?
(5) PLEASE STATE HOW THE INJURY WAS RECEIVED AS REPORTED TO YOU.	
(6) WHAT EXTERNAL EVIDENCE OF INJURY WAS VISIBLE?	
(7) DID YOU FIND ANY EVIDENCE, OR HAVE YOU ANY KNOWLEDGE OF FORMER IMPAIRMENTS, OLD INJURIES OR DISEASE AFFECTING THE INJURED LIMB OR EYE? ☐ YES ☐ NO IF SO, WHAT?	
(8) HAVE YOU PREVIOUSLY TREATED PATIENT? IS SO, WHEN - FOR WHAT: ☐ YES ☐ NO	
(9) DID YOU PERFORM ANY OPERATIONS? IF SO, STATE SPECIFICALLY THE DATE, NATURE, AND EXTENT: ☐ YES ☐ NO	
(10) IF HOSPITALIZED - NAME OF HOSPITAL ADMITTED DATE _____ HOUR _____ ☐ AM ☐ PM DISCHARGED DATE _____ HOUR _____ ☐ AM ☐ PM	
(11) WAS THERE ANY EVIDENCE OF PATIENT BEING UNDER THE INFLUENCE OF DRUGS OR INTOXICANTS PRIOR TO OR AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO	(12) WAS ANY OTHER PHYSICIAN OR SURGEON ASSOCIATED WITH YOUR ATTENDANCE UPON THE PATIENT? ☐ YES ☐ NO IF SO, PLEASE GIVE NAME AND ADDRESS:

IF INJURY RELATED TO LOSS OF LIMB(S) Please answer the following (nos. 13-16) in addition to questions 1-12.

(13) WAS AMPUTATION PERFORMED? IF SO, PLEASE DESCRIBE, GIVING DATE AND POINT OF AMPUTATION. ☐ YES ☐ NO DATE _____	
(14) WHICH LIMB WAS INVOLVED?	(15) WHAT EVIDENCE OF DISEASE, IF ANY, IS PRESENT?
(16) WAS THE INJURY DESCRIBED ABOVE, OF ITSELF, AND INDEPENDENT OF ALL OTHER CAUSES, SUFFICIENT TO REQUIRE AMPUTATION? ☐ YES ☐ NO	

IF INJURY RELATED TO LOSS OF SIGHT (EYE) Please answer the following (nos. 17-23) in addition to nos. 1-12.

(17) IS THERE, IN THE INJURED EYE(S) ANY PERCEPTION OF: LIGHT ☐ YES ☐ NO OBJECTS ☐ YES ☐ NO	(18) IS THE LENS OF EACH EYE INTACT? ☐ YES ☐ NO
(19) WHAT DEGREE OF VISION IS NOW PRESENT IN: RIGHT EYE: LEFT EYE:	
(20) WHAT TESTS WERE USED TO DETERMINE DEGREE OF VISION?	
(21) WHAT IS THE CONDITION OF PUPILLARY REFLEXES? RIGHT EYE: LEFT EYE:	
(22) IS THERE TOTAL BLINDNESS IN INJURED EYE? IF SO, ON WHAT DATE DID YOU DIAGNOSE TOTAL LOSS OF SIGHT? ☐ YES ☐ NO DATE: _____	
(23) IS LOSS OF SIGHT IRRECOVERABLE? ☐ YES ☐ NO	

DATE: _____ **SIGNED:** _____
Attending Physician

TELEPHONE: _____ **ADDRESS:** _____
(AREA) (NO.)

TIN# _____ _____
(CITY) (STATE) (ZIP)

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AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I authorize: _____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Release to: **Trustmark Life Insurance Company**
P.O. Box 7948
Lake Forest, IL 60045-7948

Specify Dates or date ranges: _____

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Health care provided to me; or
- Payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to **Trustmark Life Insurance Company** (herein as referred to "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments, tests as well as any information regarding drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, or any other public or private entity as may be lawfully required. The information provided to **Trustmark Life Insurance Company,** its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be valid as the original.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or insurance fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

_____ _____
Claimant Signature/Legal Representative Date

Fraud Statement for Alaska 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 Arizona 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 California 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 Colorado 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 Florida 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, Oregon, and Vermont 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 Kentucky 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, 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 who 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 Minnesota 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 District of Columbia, Maine, Tennessee and Virginia Residents: WARNING: 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 Statement for New Hampshire Residents
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided under RSA 638:20.

Fraud Statement for New Mexico and 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 Residents
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Delaware, Idaho, Indiana, Ohio, 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.