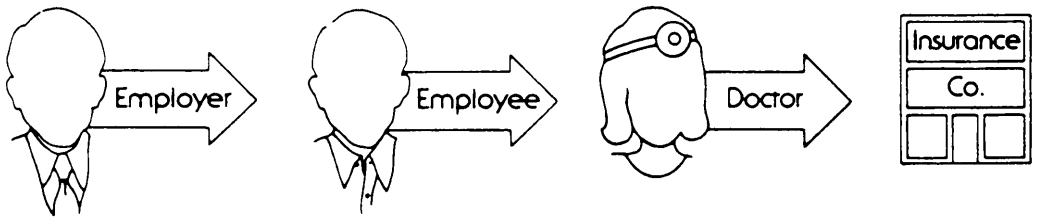
Trustmark
LIFE INSURANCE COMPANY

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

Group
Waiver of Premium/Extended Death Benefit
CLAIM
POLICYHOLDER CERTIFICATION



EMPLOYER – form completion information

NOTICE OF CLAIM — Instructions

At approximately 9 months after last day worked, but before 12 months

A. Complete the back of this form in full and transmit this portion only to address above.

Include:

- Copy of Enrollment Card

B. Give remaining portions of application to claimant for completion.

C. Include:

- Copy of Claimants Birth Certificate
- Summary of Training, Education and Experience

D. If claimant has more than one treating physician, give claimant additional forms for completion.

E. All portions of this form package must be completed to avoid undue delay in processing.

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APPLICATION FOR WAIVER OF PREMIUM/EXTENDED DEATH BENEFIT

ADMINISTRATOR'S OR EMPLOYER'S STATEMENT			
Name of Employee (First Name) (Middle Initial) (Last Name)		**Social Sec. NO.**	**Date of Birth**
Home Address			
(Street) (City) (State) (Zip Code)			

Job Title	Amount of Insurance	Annual Salary or Pension	Name of Employer

Date First Entered Our Employ	Date Last Worked	Reason for Stopping Work

LIST, IN ORDER OF IMPORTANCE, ALL DUTIES NORMAL TO THE JOB

JOB	DESCRIPTION OF DUTY	% OF TIME DEVOTED TO THIS ACTIVITY	HOURS SPENT AT THIS ACTIVITY

Physical Requirements _____

_____

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	SIGNATURE	TITLE

ATTENDING PHYSICIAN'S STATEMENT

Return To: Trustmark Life Insurance Company
P.O. Box 7948 • Lake Forest, IL 60045-7948
Phone 800-307-3929 • Fax 847-615-3866

Name of Patient	Date of Birth

HISTORY

(a) When did symptoms first appear or accident happen?

(b) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe.

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(d) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications)

(b) If pregnancy, est. date of delivery

(c) Subjective symptoms

(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)

(e) Specific restrictions and limitations

PROGRESS

(a) Has patient? ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient? ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and Address of Hospital

Confined from _____ through _____

CARDIAC

(a) Functional Capacity (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation)
☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

(b) Blood Pressure (Last Visit)

_____
Systolic/Diastolic

IMPAIRMENTS

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
☐ Class 2 - Medium manual activity*. (15 - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work*. (35 - 55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 - 70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 - 100%)

Remarks: _____

(b) Mental Impairments (If Applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
Remarks: _____

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future? ☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ Never
Applies To: ☐ Patient's Job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

(c) When could trial employment commence?
PATIENT'S JOB Date: ☐ Full-Time ☐ Part-Time
PATIENT'S JOB Date: ☐ Full-Time ☐ Part-Time

REMARKS

Reason unable to work , in detail

Name (Attending Physician) Print	Degree	Telephone

Street Address	City or Town	State or Province	Zip Code

Signature	Tax identification #	Date

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 healthy 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 as 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.