TRUSTMARK INSURANCE COMPANY, LAKE FOREST, ILLINOIS
GROUP INSURANCE EVIDENCE OF INSURABILITY

NOTE: NOT TO BE USED FOR MEDICAL OR DENTAL COVERAGE

Please type or print in ink only

1. **GROUP POLICYHOLDER INFORMATION (To be completed by Benefits Administrator)**

Name of Group Policyholder/Employer _____ Group Number _____

Division Number _____

Benefits Administrator Name _____ Phone Number ( ) _____

Benefits Administrator Address _____

Street City State Zip Code

Employee Name _____ Social Security No. _____ Date of Hire _____

Occupation _____

Employee's Address _____ Marital Status _____

Street City State Zip Code

2. COVERAGE BEING APPLIED FOR THE FOLLOWING (check all that apply, indicate amounts where necessary)

	Employee	Spouse	Child(ren)	HOME OFFICE USE ONLY Approve	Decline
Life/AD&D	$ _____	$ _____	$ _____	☐	☐
Optional Life/AD&D	$ _____	$ _____	$ _____	☐	☐
Supplemental Life/AD&D	$ _____	$ _____	$ _____	☐	☐
Short Term Disability	_____			☐	☐
Long Term Disability	_____			☐	☐
Other _____	_____	_____	_____	☐	☐

Effective Date of Coverage: _____ Underwriter: _____ Date: _____

REASON FOR EVIDENCE APPLICATION

3. ____ Late Enrollee ____ Excess Life _____ Required by Plan (explain) _____ Other _____

4. **EMPLOYEE INFORMATION (To be completed by employee)**

Complete for each person applying for insurance at this time

Name	Relationship	Male/Female	Height	Weight	Date of Birth	Full-time Student Yes/No
	Self					
	Spouse					
	Child					
	Child					
	Child					

5. Has any person proposed for coverage ever had or been treated for or consulted a physician about any of the following:

	YES	NO
A. Epilepsy, brain or nervous system disorder; mental, nervous or emotional disorder?	☐	☐
B. Respiratory or lung disorders, tuberculosis, hay fever, asthma, bronchitis, emphysema?	☐	☐
C. Diabetes, kidney disorders, gland or genitourinary tract disorder?	☐	☐
D. Stomach, intestine, rectal disorder, abdominal pain, ulcer disorder, appendix, liver or gall bladder disorder, hernia?	☐	☐
E. Arthritis; lupus; rheumatism or gout; back, spine or skeletal system disorder; bone, muscle or joint disorder?	☐	☐
F. Cancer, tumor, growth or cyst, goiter or thyroid disorder?	☐	☐
G. Congenital defect or disorder, accidental injuries?	☐	☐
H. Disorder of the reproductive organs, breast disorder, fertility problems, venereal disease, complications of pregnancy?	☐	☐
I. Impairment in sight, speech, hearing, eye, ear, nose or throat disorder?	☐	☐
J. Heart or circulatory system disorder, high blood pressure, chest pains, stroke, heart murmur, rheumatic fever, phlebitis?	☐	☐
K. Alcoholism, drug dependency or substance abuse?	☐	☐
L. Disorder of the blood, immune system or lymph nodes including AIDS or ARC?	☐	☐
6. To the best of your knowledge, other than admitted to in Question #5, has any person for whom application is being made including yourself, spouse, and any dependents been examined or treated by a medical practitioner, undergone a surgical procedure or been hospitalized (including pregnancy) in the past 5 years?	☐	☐

	Yes	No
7. Do you or anyone proposed for coverage plan to visit a medical practitioner or have an operation for any existing injury or illness?	☐	☐
8. During the past 12 months have you or any proposed insured had any medical consultation, advice or treatment by a medical practitioner, had medication prescribed, had surgery, or been confined in a hospital, psychiatric or school and drug dependency facility (inpatient or outpatient), or been advised by a medical practitioner, that a hospital confinement, and/or surgery will be needed during the next 6 months?	☐	☐
9. Has any person proposed for coverage ever been declined, postponed, rated or limited for life or health insurance?	☐	☐
10. Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months? If yes, amount per day_____ ; and for how long_____ .	☐	☐
11. Is any person proposed for coverage now pregnant? If yes, approximate due date_____ .	☐	☐

For any questions answered "YES" in items #5 through 9, please supply the following information, and be as specific as possible

Question Number	Person's Name	Condition, Injury or Symptom of Ill Health (Name of Operation Performed)	Date Of Onset	Date Last Treated	Results/Prognosis (List Current Medications and Dosages)

AGREEMENTS

The answers and statements on this application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by Trustmark at its Home Office.

I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

MEDICAL AUTHORIZATION

I authorize any of the following to disclose to Trustmark Insurance Company, Lake Forest, Illinois, any data it has on me or my health or on the health of my family: (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical related facility; (3) any insurance company; (4) the Medical Information Bureau; or (5) any other organization, institution or person that has data on me or my health or on the health of my family. I specifically authorize the release of information on alcohol or drug abuse and mental illness. I also authorize such disclosure of data to the reinsurer of Trustmark Insurance Company. I waive, to the extent allowed by law, all provisions of law forbidding such disclosure. I make such waiver on behalf of myself and any person who shall have or claim any interest on any insurance issued hereon. A copy of this shall be as valid as the original.

FRAUD WARNING

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.

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

In compliance with Public Law 91-508, an investigative consumer report may be made within the next few days which will provide applicable and relevant material concerning character, general reputation, personal characteristics and mode of living of any persons to be covered. This report will be obtained through personal interviews with friends, neighbors, and associates. Upon written request to the Company, a complete and accurate disclosure of the nature and scope of the investigative consumer report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. Trustmark Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information on you it may file. (Medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, Massachusetts 02112, telephone number: (617) 426-3660.

Trustmark Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

IMPORTANT

ALL FEES FOR DOCTOR'S STATEMENT OR EXAMINATIONS ARE THE RESPONSIBILITY OF THE APPLICANT. TRUSTMARK ASSUMES NO RESPONSIBILITY FOR PAYMENT OF SUCH FEES.

Please return this completed form to your Benefits Administrator at the following Address:

x_____

Signature of Employee/Applicant Date