



In Furnishing this form the Trustmark Life Insurance Company does not waive any of its rights or defenses nor admit liability

Underwritten By  
 Trustmark Life  
 Insurance Company

**TRUSTMARK LIFE INSURANCE COMPANY, LAKE FOREST, ILLINOIS  
 GROUP LIFE 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**

Employer's Name \_\_\_\_\_ Group Number \_\_\_\_\_

Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Occupation \_\_\_\_\_

Employee's Address \_\_\_\_\_

Street City State Zip Code

**2. 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					

3. 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?  Yes  No
- B. Respiratory or lung disorders, tuberculosis, hay fever, asthma, bronchitis, emphysema?  Yes  No
- C. Diabetes, kidney disorders, gland or genitourinary tract disorder?  Yes  No
- D. Stomach, intestine, rectal disorder, abdominal pain, ulcer disorder, appendix, liver or gall bladder disorder, hernia?  Yes  No
- E. Arthritis; lupus; rheumatism or gout; back, spine or skeletal system disorder; bone, muscle or joint disorder?  Yes  No
- F. Cancer, tumor, growth or cyst, goiter or thyroid disorder?  Yes  No
- G. Congenital defect or disorder, accidental injuries?  Yes  No
- H. Disorder of the reproductive organs, breast disorder, fertility problems, venereal disease, complications of pregnancy?  Yes  No
- I. Impairment in sight, speech, hearing, eye, ear, nose or throat disorder?  Yes  No
- J. Heart or circulatory system disorder, high blood pressure, chest pains, stroke, heart murmur, rheumatic fever, phlebitis?  Yes  No
- K. Alcoholism, drug dependency or substance abuse?  Yes  No
- L. Disorder of the blood or lymph nodes?  Yes  No

4. Has any person proposed for coverage been diagnosed or treated by a member of the medical profession for an immune system disorder or for AIDS or ARC?  Yes  No

Yes No

- 5. To the best of your knowledge, other than admitted to in Question #3, 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?
- 6. Do you or anyone proposed for coverage plan to visit a medical practitioner or have an operation for any existing injury or illness?
- 7. 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?
- 8. Has any person proposed for coverage ever been declined, postponed, rated or limited for life or health insurance?
- 9. 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 \_\_\_\_\_ .
- 10. Is any person proposed for coverage now pregnant?    
If yes, approximate due date \_\_\_\_\_ .

For any questions answered "YES" in items #3 through 8, 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 Life Insurance Company 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 Life 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 Life 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 an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

**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 Life Insurance Company or its reinsurers may, however, make a brief report to MIB, Inc., formerly known as 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, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901.

Trustmark Life 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 LIFE INSURANCE COMPANY 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