INSTRUCTIONS

The STATEMENT OF PHYSICIAN section must be completed by the deceased's primary care physician, ONLY if the death occurred within the first 2 years from the effective date of the policy.

A BENEFICIARY'S STATEMENT must be completed by the person to whom the insurance is payable. In connection with such statement, the following should be observed:

(1) If there is more than one beneficiary, all may join in one statement or a separate form will be furnished for each if desired.

(2) If the policy is payable to the estate or to the executors or administrators of the insured, the statement should be completed by the executor or administrator, a certificate of whose appointment and qualifications must be furnished.

(3) If the policy is payable to a minor or a mentally incompetent person, the statement should be completed by a guardian, a certificate of whose appointment and qualifications must be furnished.

(4) If the policy has been assigned, special instructions will be furnished.

A CERTIFIED COPY OF THE DEATH CERTIFICATE must be furnished.

A certified copy of the death certificate of any deceased beneficiary must be furnished.

If the cause of death is due to an injury or accident, enclose a photocopy of the police report and/or newspaper articles concerning the circumstances.

TRUSTMARK
INSURANCE COMPANY

Attn: Life Claims • 100 North Parkway • Ste. 200 • Worcester, Massachusetts 01605 • 1-800-918-8877 • FAX 508-853-0310

LIFE INSURANCE BENEFICIARY'S STATEMENT

Policies of this Company under which claim is being made:

Policy Number _____

1. (a) Deceased's name in full _____

   (b) Residence address _____

   (c) Insured was totally disabled prior to Death? ☐ Yes ☐ No As of what Date? _____

2. Date of BIRTH of deceased _____

3. (a) When did deceased first complain of or give other indications of the last illness? _____

   (b) When did deceased first consult a physician for the last illness? _____

4. Names and addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death:

Physician Name	Addresses	Phone/Fax Numbers	Disease or Condition

5. Has deceased at any time been confined to a hospital? ☐ Yes ☐ No
   (If yes, state when and where). When _____

   Where _____

6. (a) Date of death _____ Place of death _____

   (b) Cause of death _____

7. If optional settlement is available and you do not desire payment in one sum, state type of settlement desired.

_____

*****COMPLETE AND SIGN DISCLOSURE AUTHORIZATION ON THE LAST PAGE*****

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STATEMENT OF PHYSICIAN

1. (a) Deceased's name in full _____ Age at death _____

   (b) Residence at death _____ Occupation _____

2. How long have you known the deceased? _____

3. (a) Date of death _____ Place of death _____ Time of death _____

   (b) If death occurred in hospital please give name and address _____

   (c) When were you first consulted for the conditions which directly or indirectly caused death? _____

   _____

4. (a) What was the immediate cause of death? _____

   (b) How long in your opinion did this disease or impairment exist? _____

   (c) What was the date of onset of the first symptom or sign according to the clinical history? _____

   (d) From what date was the patient continuously totally disabled prior to death? _____

5. (a) Contributory cause of death _____

   _____ Duration _____

   (b) Other chronic diseases or impairments _____

   _____ Duration _____

6. Please give particulars of each condition for which you treated or advised deceased prior to last illness.

Disease or Condition	Date	Duration	Result

7. Please give name and addresses of all other physicians or other practitioners who attended deceased within the five years preceding death.

Name	Address/Phone	Disease or Impairment

Signature _____ M.D. Date _____

Telephone ( ) _____ Fax ( ) _____

Address _____

(Street Number) (City) (State) (Zip)

State Required Fraud Warnings

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.

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.

California Residents - For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

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 purposes 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.

Kansas and Oregon 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.

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.

Arkansas, Louisiana 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.

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 WARNING FOR WASHINGTON, MAINE, TENNESSEE AND VIRGINIA RESIDENTS: 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 AND DENIAL OF INSURANCE BENEFITS.

FRAUD WARNING FOR 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.

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 Oklahoma, as well as for the residents of all states not specifically listed WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning 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 Warning for District of Columbia Residents - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Fraud Warning for New Mexico 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 CIVIL FINES AND CRIMINAL PENALTIES.

Fraud Warning for Ohio Residents - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Warning for Texas Residents - 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 Warning 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.

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DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of the insured or his or her health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to the physical or mental condition or information concerning the insured, his/her occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about the insured to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the duration of the claim. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

RESIDENTS OF NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Residents of Florida – Any person who knowing and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of NY – 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 or each such violation.

Date: _____ Signature: _____

Print Name: _____

Date of Birth:_____/_____/_____ Relationship:_____

Social Security Number: _____ Daytime Phone Number: (____)_____

_____

Street Address City State ZIP

Date: _____ Signature: _____

Print Name: _____

Date of Birth:_____/_____/_____ Relationship:_____

Social Security Number: _____ Daytime Phone Number: (____)_____

_____

Street Address City State ZIP