

# TRUSTMARK

INSURANCE COMPANY

400 FIELD DRIVE • LAKE FOREST, ILLINOIS 60045-2581

## PROOF OF DEATH STATEMENTS

### PART I - STATEMENT OF BENEFICIARY

|  |  |   |   |
|--|--|---|---|
| (1) NAME OF DECEASED (AS APPEARS IN POLICY)  |  | (2) DECEASED'S DATE OF BIRTH  | (3) POLICY NUMBER   |
| (4) DECEASED'S HOME ADDRESS - NO. AND STREET   |  | CITY  | STATE   |
| (5) POLICY AMOUNT  |  | (6) NAME AND ADDRESS OF DECEASED'S EMPLOYER   |   |
| (7) DECEASED'S OCCUPATION WHEN INJURED OR ON THE LAST DAY HE WORKED.   |  | (8) DATE OF ACCIDENT  |   |
| (9) TIME OF ACCIDENT<br>_____ <input type="checkbox"/> AM <input type="checkbox"/> PM  |  | (10) WHERE DID ACCIDENT HAPPEN?   |   |
| (11) HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)   |  |   |   |
| (12) WHAT INJURIES DID DECEASED RECEIVE?   |  |   |   |
| (13) WHEN DID HE QUIT WORK?<br>DATE _____ HOUR _____ <input type="checkbox"/> AM <input type="checkbox"/> PM   |  | (14) WHEN DID THE DEATH OCCUR?<br>DATE _____ HOUR _____ <input type="checkbox"/> AM <input type="checkbox"/> PM |   |
| (15) WHEN DID DECEASED FIRST CONSULT A PHYSICIAN FOR THIS INJURY?<br>DATE _____ PHYSICIAN'S NAME AND ADDRESS:  |  |   |   |
| (16) NAME AND ADDRESS OF ANY OTHER PHYSICIAN (S) CONSULTED FOR THIS INJURY:  |  |   |   |
| (17) IF HOSPITALIZED - NAME AND ADDRESS OF HOSPITAL  |  | DATE ADMITTED<br>DATE _____ <input type="checkbox"/> AM<br>HOUR _____ <input type="checkbox"/> PM               | DATE DISCHARGED<br>DATE _____ <input type="checkbox"/> AM<br>HOUR _____ <input type="checkbox"/> PM |
| (18) WAS AN AUTOPSY OR CORONER'S INQUEST HELD?<br><input type="checkbox"/> NO <input type="checkbox"/> YES<br>IF "YES", A REPORT OF THE AUTOPSY AND A COPY OF THE FINDINGS OF THE INQUEST MUST ACCOMPANY THIS FORM.  |  |   |   |
| (19) WAS DECEASED INSURED IN ANY OTHER COMPANY, ASSOCIATION OR LODGE FOR THIS LOSS?<br><input type="checkbox"/> NO <input type="checkbox"/> YES<br>IF "YES" GIVE NAME OF COMPANIES: _____ AMOUNT OF INSURANCE? _____ |  |   |   |

**AUTHORIZATION** - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or consumer reporting agency, or employer having any records or information pertaining to all medical history, mental or physical condition, evaluation, diagnosis, treatment or prognosis, specifically to include psychiatric, drug or alcohol abuse treatment concerning the deceased and any other non-medical information concerning the deceased to give to TRUSTMARK INSURANCE COMPANY, Lake Forest, Illinois (TMK) or its legal representatives, any and all such information. I further acknowledge that the information obtained by use of this Authorization will be used by TMK to determine my eligibility for benefits. I understand that I may request a copy of this Authorization. I further agree that a photostatic copy of this Authorization shall be as valid as the original, and that such Authorization shall be valid for two years from the date shown below.

Beneficiary's Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

Beneficiary's Address \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_  
City State Zip Code



**PART IV - STATEMENT OF ATTENDING PHYSICIAN**

(1) NAME OF DECEASED \_\_\_\_\_

(2) HOW LONG HAVE YOU KNOWN HIM? \_\_\_\_\_

(3) IF YOU HAVE PREVIOUSLY TREATED HIM, (A) WHEN? \_\_\_\_\_  
MONTH DATE YEAR

(B) FOR WHAT? \_\_\_\_\_

(4) WHEN DID YOU FIRST ATTEND DECEASED FOR INJURIES CAUSING DEATH? \_\_\_\_\_

(5) GIVE THE DATE OF DEATH \_\_\_\_\_

(6) STATE THE IMMEDIATE CAUSE OF DEATH \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(7) STATE ANY REMOTE OR CONTRIBUTING CAUSE OF DEATH \_\_\_\_\_  
\_\_\_\_\_

(8) WHAT EXTERNAL EVIDENCE OF INJURY CAUSING DEATH WAS VISIBLE UPON THE BODY OF DECEASED, AND WHEN DID YOU FIRST NOTICE SAME?  
\_\_\_\_\_  
\_\_\_\_\_

(9) (A) WAS THERE A POST - MORTEM EXAMINATION? IF SO, BY WHOM, AND WHAT FACTS WERE DEVELOPED? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(B) WAS BLOOD ALCOHOL LEVEL TAKEN? \_\_\_\_\_ OTHER DRUG LEVEL TAKEN? \_\_\_\_\_ RESULT \_\_\_\_\_

(10) IF IN A HOSPITAL GIVE ITS NAME \_\_\_\_\_

(A) DATE ENTERED HOSPITAL \_\_\_\_\_ 19 \_\_\_\_\_ HOUR \_\_\_\_\_ AM \_\_\_\_\_ PM  
MONTH DAY

(B) DATE OF DISCHARGE \_\_\_\_\_ 19 \_\_\_\_\_ HOUR \_\_\_\_\_ AM \_\_\_\_\_ PM  
MONTH DAY

(11) HAD THE DECEASED ANY BODILY WEAKNESS. INFIRMITY OR DEFORMITY? IF SO, GIVE PARTICULARS \_\_\_\_\_  
\_\_\_\_\_

(12) WAS THERE ANY EVIDENCE OF THE DECEASED BEING UNDER THE INFLUENCE OF INTOXICANTS OR DRUGS PRIOR TO OR AT THE TIME OF THE  
ACCIDENT? IF SO, PLEASE EXPLAIN \_\_\_\_\_

(13) WAS THE INJURY SELF-INFLICTED OR INCURRED AS THE RESULT OF VIOLATION OF THE LAW? \_\_\_\_\_

(14) STATE ANY OTHER MATERIAL FACTS WHICH MAY RELATE DIRECTLY OR INDIRECTLY TO CAUSE OF DEATH? \_\_\_\_\_  
\_\_\_\_\_

(15) NAME AND ADDRESS OF ANY OTHER PHYSICIAN (S) IN ATTENDANCE UPON DECEASED? \_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

ATTENDING PHYSICIAN

TELEPHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
(AREA) (NO.)

# PROOF OF DEATH STATEMENTS

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health to disclose to Trustmark Insurance Company, Lake Forest, Illinois, any such information. A copy of this authorization shall be considered as valid as the original.

## INSTRUCTIONS:

**BENEFICIARY:** Complete part I. Have Eye Witness complete part II. Note - If no Eye Witness was present at the time of accident, part II should be completed by the first person to reach member immediately after the accident.

Have deceased's Employer complete part III (STATEMENT OF EMPLOYER). Have Attending Physician complete part IV (STATEMENT OF ATTENDING PHYSICIAN).

A certified copy of the death certificate must accompany this form. Please attach any newspaper clippings giving information about the accident. Also, if autopsy or coroner's inquest was held a report of the autopsy and a copy of the inquest findings must accompany this form.

In some states, we are required to inform you that: any 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, may be committing a fraudulent insurance act, which is a crime.

In Florida we are required to inform you 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 is guilty of a felony of third degree.

In California and New Jersey we are required to inform you that: any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

In Minnesota we are required to inform you that: a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.