

Trustmark

LIFE INSURANCE COMPANY

Coordination of Benefits

Member's Name: _____ SS#: _____

Member's Address: _____

Group Name/Number: _____

Please answer the following questions and return to the above address. We require updated information concerning other group coverage on an annual basis. Please notify us immediately if information changes.

1. Please furnish the following information on any family member who has other insurance, including Medicare.

Name of Insured: _____ SS#: _____

Insured's Date of Birth: _____

Carrier or Policy Number: _____

Name of other insurance carrier: _____

Phone number of other insurance carrier: _____

2. Type of Coverage (select all that apply):

Medical Dental Vision Medicaid Medicare

3. Plan Coverage (select all that apply):

Individual Member Only Member/Spouse Member/Child(ren) Member/Family

4. Please list the individuals under the plan and their relationship to the insured.

Name: _____ Relationship: _____ Effective Date: _____

Name: _____ Relationship: _____ Effective Date: _____

Name: _____ Relationship: _____ Effective Date: _____

Name: _____ Relationship: _____ Effective Date: _____

Name: _____ Relationship: _____ Effective Date: _____

I certify that the above information is true to the best of my knowledge.

(Signature) **Date:** _____