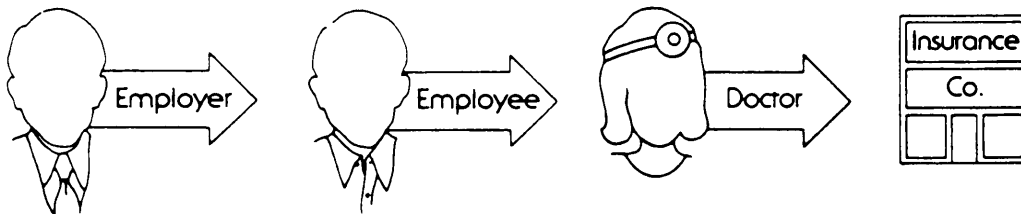


Group Long Term Disability **CLAIM**

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 30 days before end of elimination period:

A. *Complete the back of this form in full and transmit this portion only to address above.*

- Include:*
- *Job description (detailed duties)*
 - *Copy of enrollment card (if employee contributes to premium)*
 - *Copy of approved medical evidence of insurability if required at time of enrollment*
 - *Documentation of earnings if other than straight salary*
 - *If Workers' Compensation claim filed include copy of First Report of Accident and the decision*

B. *Give remaining two-part form to claimant for completion*

- Request*
- *Birth certificate (short duration claim and under age 50 not necessary at this time)*
 - *Copy of awards from other source of benefits: Social Security, Workers' Comp., retirement, state disability, others*

C. *If claimant has more than one treating physician, give claimant additional forms for completion.*

D. *All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.*

EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT	1. Employee's Name _____		2. Social Security No. _____	3. Date of Birth _____	
	4. Address _____		City _____	State _____	Zip Code _____
EMPLOYMENT	5. Insurance Class _____		6. Employee Date of Hire _____		7. Date employee became Insured for LTD _____
	8. Date employee was actually last present at work _____		9. Occupation at time last worked (attach job description) _____		
	10. Work schedule at time last worked No. of days per week _____ No. of hours per day _____			11. Reason for stopping: <input type="checkbox"/> Sickness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Other <input type="checkbox"/> Resigned <input type="checkbox"/> Vacation	
INCOME	12. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> No Date _____ Date _____		13. How is employee paid? <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Salary & Commissions <input type="checkbox"/> Salary & Bonus <input type="checkbox"/> Commissions Only <input type="checkbox"/> Other		
	14. Employee's Basic Monthly Earnings \$ _____ LTD Benefit _____ (If salary is based on less than 12 mos. – No. of mos. _____)			15. Employee's % of LTD premium contribution: Employee pays _____ Employer pays _____	
OTHER BENEFITS	16. Has insured received other disability payments since time last worked? Salary Continuance: <input type="checkbox"/> Yes Wkly. Amt. _____ Date benefits cease _____ <input type="checkbox"/> No				
	Insured Short Term: <input type="checkbox"/> Yes Wkly. Amt. _____ Date benefits cease _____ <input type="checkbox"/> No Other Type: _____ <input type="checkbox"/> Yes Wkly. Amt. _____ Date benefits cease _____ <input type="checkbox"/> No				
RETIREMENT	17. Did claim result from job activity? <input type="checkbox"/> Yes (Explain) _____ <input type="checkbox"/> No		18. Has Workers' compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> Denied (Enc. copy) <input type="checkbox"/> No		19. Workers' compensation Wkly. Amt. \$ _____ (Inc. copy of 1st report of accident)
	20. Is employee covered by employer sponsored retirement plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Does retirement plan contain a disability provision? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. Is employee or will this employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes If "Yes" type: _____ Monthly Amount \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other Commence Date of Benefits: _____ (enclose copy of summary plan description)					
NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.					
CERTIFICATION	23. Employer's Name (state association and name of policyholder, if other) _____		24. Telephone No. _____		25. Group Policy No. _____
	26. Address _____				
	27. Employer (Taxpayer) I.D. Number (EIN) _____ – _____ OR		29. Name of person completing this form (please type or print) _____		
	28. Public Employer Social Security No. 69 _____ – _____		30. Signature of Authorized Insurance Representative _____ Title _____ Date _____		

Separate and send this form (with other enclosures) to address on reverse side. Give remaining portions of form to claimant for completion.


GROUP LONG TERM DISABILITY CLAIM APPLICATION

TO BE COMPLETED BY EMPLOYEE

CLAIMANT	1. Full Name (Last, First, Middle Init.)			2. Social Security No.			3. Phone Number																																																						
	4. Address			City			State			Zip Code																																																			
	5. Date of birth <small>Mo. Day Year</small>		6. Height	7. Weight	8. Sex <input type="checkbox"/> M <input type="checkbox"/> F		9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			10. Spouse's date of birth <small>Mo. Day Year</small> First Name		11. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																	
	12. Number of children (Under age 19)			13. List names and dates of birth of unmarried children who have not finished high school.																																																									
EMPLOYMENT	14. Employer's Name						15. Group Policy No.																																																						
	16. Occupation (List the duties of your occupation at the time of disability)																																																												
	17. Date of accident or date first noticed symptoms of illness: <small>Mo. Day Year</small>			18. I have been unable to work because of the disability since: <small>Mo. Day Year</small>			19. I returned to work on a part time basis on: <small>Mo. Day Year</small>			20. I returned to work on a full time basis on: <small>Mo. Day Year</small>																																																			
	21. Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			22. If "yes," explain Have you or do you intend to file a Workers' Comp. Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																									
CLAIM HISTORY	23. Describe how and where accident occurred or describe the onset and nature of your illness.																																																												
	24. Date you were first treated for your illness or injury. <small>Mo. Day Year</small>			25. Treated by: Hospital: _____ <small>Name Street Address City State Zip Code</small> Doctor: _____ <small>Name Street Address City State Zip Code</small>																																																									
	26. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete No. 27.			27. Treated by: Hospital: _____ <small>Name Street Address City State Zip Code</small> Doctor: _____ <small>Name Street Address City State Zip Code</small>																																																									
	28. Describe other income you are receiving:																																																												
INCOME	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:10%;">yes</th> <th style="width:10%;">no</th> <th style="width:30%;">type</th> <th style="width:10%;">amount</th> <th style="width:10%;">date began</th> <th style="width:10%;">date term.</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>Social Security (disability or retirement)</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>State disability</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>Retirement (normal, early or disability)</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>Workers' Compensation</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>Group disability benefits</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>Other (describe) _____</td> <td>\$ _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>													yes	no	type	amount	date began	date term.	<input type="checkbox"/>	<input type="checkbox"/>		Social Security (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		State disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		Retirement (normal, early or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		Group disability benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		Other (describe) _____	\$ _____	_____	_____
		yes	no	type	amount	date began	date term.																																																						
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<input type="checkbox"/>	<input type="checkbox"/>		Other (describe) _____	\$ _____	_____	_____																																																							
29. Have you, or do you plan to apply for benefit described above?																																																													
<table style="width:100%; border-collapse: collapse;"> <tr> <td>Type _____</td> <td>Date application filed _____</td> </tr> <tr> <td>Type _____</td> <td>Date application filed _____</td> </tr> </table>												Type _____	Date application filed _____	Type _____	Date application filed _____																																														
Type _____	Date application filed _____																																																												
Type _____	Date application filed _____																																																												
BENEFIT	30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" Amt. \$ _____ <small>Indicate amount per month \$80.00 min.</small>																																																												
												Signature _____																																																	
The above statements are true and complete to the best of my knowledge and belief.																																																													
_____											Date _____																																																		
Signature of Employee																																																													

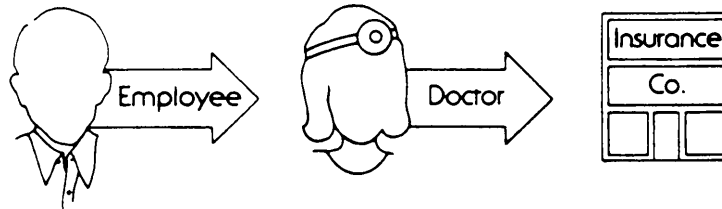
Return To: **Trustmark Life Insurance Company**
P. O. Box 7948
Lake Forest, IL 60045-7948

ATTENDING PHYSICIAN'S STATEMENT

<i>Name of Patient</i>		<i>Date of Birth</i>	
HISTORY	<i>(a) When did symptoms first appear or accident happen?</i>	<i>(b) Date patient ceased work because of disability?</i>	<i>(c) Has patient ever had same or similar condition?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If "Yes", state when and describe.</small>
	<i>(d) Is condition due to injury or sickness arising out of patient's employment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>(e) Names and addresses of other treating physicians</i>
DIAGNOSIS	<i>(a) Diagnosis (Including complications)</i>	<i>(b) If pregnancy, est. date of delivery</i>	<i>(c) Subjective symptoms</i>
	<i>(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)</i>		
TREATMENT	<i>(a) Date of first visit</i>	<i>(b) Date of last visit</i>	<i>(c) Frequency:</i> <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)
	<i>(d) Nature of treatment (Including surgery and medications prescribed, if any)</i>		
PROGRESS	<i>(a) Has patient?</i> <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?		<i>(b) Is patient?</i> <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> Hospital Confined?
	<i>(c) Has patient been hospital confined?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If yes, give Name and Address of Hospital</i> Confined from _____ through _____
CARDIAC	<i>(a) Functional Capacity (American Heart Association)</i> <input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)		<i>(b) Blood Pressure (Last Visit)</i> _____ / _____ Systolic/Diastolic
	<i>(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)</i> <input type="checkbox"/> Class 1 – No limitation of functional capacity; capable of heavy work*. No restrictions. (0 – 10%) <input type="checkbox"/> Class 2 – Medium manual activity*. (15 – 30%) <input type="checkbox"/> Class 3 – Slight limitation of functional capacity; capable of light work*. (35 – 55%) <input type="checkbox"/> Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 – 70%) <input type="checkbox"/> Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 – 100%) Remarks: _____		
IMPAIRMENTS	<i>(b) Mental Impairments (If Applicable)</i> <i>(a) Please define "stress" as it applies to this claimant.</i> <i>(b) What stress and problems in interpersonal relations has claimant had on job?</i> <input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks: _____		
	<i>(a) Is patient now totally disabled?</i> PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		
PROGNOSIS	<i>(b) Date patient became disabled due to present illness</i>		
	<i>(c) When do you expect a fundamental or marked change in the future?</i> <input type="checkbox"/> 1 Month <input type="checkbox"/> 1 – 3 Months <input type="checkbox"/> 3 – 6 Months <input type="checkbox"/> Never Applies To: <input type="checkbox"/> Patient's Job <input type="checkbox"/> Other Work		
REHAB	<i>(a) Is patient a suitable candidate for occupational rehabilitation?</i> PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>(b) Can present job be modified to allow for handling with impairment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>(c) When could trial employment commence?</i> Date: _____ PATIENT'S JOB <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Date: _____ ANY OTHER WORK <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		
REMARKS	<i>(Limitations, Therapy, etc.)</i>		
			
<i>Name (Attending Physician) Print</i>		<i>Degree</i>	<i>Telephone</i>
<i>Street Address</i>		<i>City or Town</i>	<i>State or Province</i> <i>Zip Code</i>
<i>Signature</i>			<i>Date</i>

Group Long Term Disability **CLAIM**

APPLICATION



EMPLOYER — *form completion information*

Application for Group LTD— Instructions

- A. Complete and sign the authorization on the reverse side of this page. This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).
- B. Completion employee claim statement in full.
Attach:
 - A copy of your birth certificate if disability is indefinite
 - A copy of Social Security and other income entitlement awards (or forward when received)
- C. Give this authorization and attached claim application to the physician treating you (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.
- D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

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.

Do Not Detach

Group LTD CLAIM

EMPLOYEE'S Authorization for Release of Information

AUTHORIZATION — To Be Completed By Employee

Policy No. _____

To Whom It May Concern:

I, _____
Claimant's Name hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company, Social Security Administration or any other Governmental Agency to disclose or furnish to Trustmark Life Insurance Company, its subsidiaries or representatives, any and all information with respect to any illness including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to Trustmark Life Insurance Company, its subsidiaries or representatives is to be used solely for the administration of claim(s) as captioned above. A photostatic copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

Date

Patient's (Claimant's) Signature

Relationship of Authorized Person, If Other

Authorized Person's Signature

NOTE: A true copy of this authorization is available to the patient or his authorized representative at any time, upon request.