Trustmark
LIFE INSURANCE COMPANY

P.O. Box 7948 • Lake Forest, IL 60045-7948
Phone 1-800-290-8899 • Fax (847) 615-3946

PROOF OF LOSS OF LIMB(S) OR SIGHT STATEMENTS

PART I — STATEMENT OF INSURED

(1) NAME (AS APPEARS IN POLICY)

(2) DATE OF BIRTH

(3) SOCIAL SECURITY NO.

(4) HOME ADDRESS — NO. AND STREET CITY STATE

(5) POLICY NUMBER

(6) NAME AND ADDRESS OF EMPLOYER

(7) YOUR OCCUPATION WHEN INJURED OR ON THE LAST DAY YOU WORKED.

(8) DATE OF ACCIDENT

(9) TIME OF ACCIDENT ________ ☐ AM ☐ PM

(10) WHERE DID ACCIDENT HAPPEN?

(11) HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

(12) WHAT INJURIES DID YOU RECEIVE?

(13) WHEN DID YOU STOP WORKING?
DATE ________ HOUR ________ ☐ AM ☐ PM

(14) HAVE YOU RETURNED TO WORK?
☐ YES ☐ NO

(15) DATE OF RETURN TO WORK

(16) WHEN DID YOU FIRST CONSULT A PHYSICIAN FOR THIS INJURY?
DATE ________ PHYSICIAN'S NAME AND ADDRESS:

(17) NAME AND ADDRESS OF ANY OTHER PHYSICIAN(S) CONSULTED FOR THIS INJURY:

(18) WHEN DID TOTAL LOSS OF LIMB(S) OR SIGHT OCCUR?

(19) DID YOU HAVE ANY PREVIOUS INJURY, DEFECT OR DISEASE WHICH AFFECTED THE INJURED LIMB(S) OR EYE?
☐ YES ☐ NO

(20) IF HOSPITALIZED — NAME OF HOSPITAL

DATE ADMITTED
DATE ________ ☐ AM
HOUR ________ ☐ PM

DATE DISCHARGED
DATE ________ ☐ AM
HOUR ________ ☐ PM

(21) ARE YOU MAKING CLAIM AGAINST ANY OTHER COMPANY, ASSOCIATION OR LODGE FOR THIS LOSS?
☐ YES ☐ NO IF SO, GIVE NAME OF ORGANIZATION

(22) HAVE YOU MADE ANY CLAIM AGAINST THIS COMPANY BEFORE?
☐ YES ☐ NO

AUTHORIZATION

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 Life Insurance Company, Lake Forest, Illinois, any such information. A copy of this authorization shall be considered as valid as the original.

DATE ________________ **Insured's Signature** ________________

Attending Physician Please Complete Part IV.

PART II — STATEMENT OF EYE WITNESS

IF NO EYE WITNESS PRESENT, THIS PART SHOULD BE COMPLETED BY THE FIRST PERSON TO REACH MEMBER IMMEDIATELY AFTER THE ACCIDENT

(1) WERE YOU PRESENT WHEN THE ACCIDENT OCCURRED?

☐ YES ☐ NO

(2) DID YOU WITNESS THE ACCIDENT?

☐ YES ☐ NO

(3) ARE YOU PERSONALLY ACQUAINTED WITH THE INSURED? ☐ YES ☐ NO

IF YES, CHECK THE FOLLOWING ☐ FELLOW WORKER ☐ FRIEND ☐ RELATIVE

(4) WHERE WAS THE CLAIMANT WHEN INJURED AND WHAT WAS HE DOING?

(5) DESCRIBE THE ACCIDENT FULLY, GIVING ALL THE PARTICULARS:

DATE ______________________

Telephone ______________________
(Area) (No.)

SIGNED ______________________

ADDRESS ______________________

____
(City) (State) (Zip)

PART III — STATEMENT OF EMPLOYER

(1) NAME OF EMPLOYEE

(2) WHAT WAS HIS OCCUPATION ON THE DAY HE WAS INJURED OR ON LAST DAY HE WORKED?

(3) IS DISABIILITY A RESULT OF EMPLOYMENT?

☐ YES ☐ NO

IF SO, PLEASE STATE FULLY HOW THE EMPLOYEE WAS HURT AND WHAT HE WAS DOING AT THAT TIME:

(4) DID ACCIDENT HAPPEN AWAY FROM WORK?

☐ YES ☐ NO

IF SO, PLEASE GIVE DETAILS AS REPORTED TO YOU:

(5) WHEN DID INJURY HAPPEN?

DATE ____________ HOUR ________ ☐ AM ☐ PM

(5) WHEN DID THE EMPLOYEE STOP WORKING?

DATE ____________ HOUR ________ ☐ AM ☐ PM

(7) HAS EMPLOYEE RETURNED TO WORK? IF SO, WHEN.

☐ YES ☐ NO DATE ____________

(8) WAS THERE ANY EVIDENCE OF THE EMPLOYEE BEING UNDER THE INFLUENCE OF INTOXICANTS OR DRUGS PRIOR TO OR AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

EMPLOYER ______________________ ADDRESS ______________________
ST. NO. CITY STATE

SIGNED ______________________ TITLE ____________ TELEPHONE ______________ DATE ____________
(AREA) (NO.)

PART IV — STATEMENT OF ATTENDING PHYSICIAN

(1) NAME OF PATIENT

(2) WHEN DID YOU FIRST ATTEND PATIENT FOR THIS INJURY?
DATE ______________

(3) WHEN DO YOU UNDERSTAND THE INJURY WAS RECEIVED
DATE ______________ HOUR __________ ☐ AM ☐ PM

(4) WHERE DID ACCIDENT HAPPEN?

(5) PLEASE STATE HOW THE INJURY WAS RECEIVED AS REPORTED TO YOU.

(6) WHAT EXTERNAL EVIDENCE OF INJURY WAS VISIBLE?

(7) DID YOU FIND ANY EVIDENCE, OR HAVE YOU ANY KNOWLEDGE OF FORMER IMPAIRMENTS, OLD INJURIES OR DISEASE AFFECTING THE INJURED LIMB OR EYE?
☐ YES ☐ NO IF SO, WHAT?

(8) HAVE YOU PREVIOUSLY TREATED PATIENT? IF SO, WHEN — FOR WHAT:
☐ YES ☐ NO

(9) DID YOU PERFORM ANY OPERATIONS? IF SO, STATE SPECIFICALLY THE DATE, NATURE, AND EXTENT:
☐ YES ☐ NO

(10) IF HOSPITALIZED — NAME OF HOSPITAL

ADMITTED
DATE ______________
HOUR ______________ ☐ AM ☐ PM

DISCHARGED
DATE ______________
HOUR ______________ ☐ AM ☐ PM

(11) WAS THERE ANY EVIDENCE OF PATIENT BEING UNDER THE INFLUENCE OF DRUGS OR INTOXICANTS PRIOR TO OR AT THE TIME OF THE ACCIDENT?
☐ YES ☐ NO

(12) WAS ANY OTHER PHYSICIAN OR SURGEON ASSOCIATED WITH YOUR ATTENDANCE UPON THE PATIENT?
☐ YES ☐ NO
IF SO, PLEASE GIVE NAME AND ADDRESS:

IF INJURY RELATED TO LOSS OF LIMB(S) Please answer the following (nos. 13-16) in addition to questions 1-12.

(13) WAS AMPUTATION PERFORMED? IF SO, PLEASE DESCRIBE, GIVING DATE AND POINT OF AMPUTATION.
☐ YES ☐ NO DATE ______________

(14) WHICH LIMB WAS INVOLVED?

(15) WHAT EVIDENCE OF DISEASE, IF ANY, IS PRESENT?

(16) WAS THE INURY DESCRIBED ABOVE, OF ITSELF, AND INDEPENDENT OF ALL OTHER CAUSES, SUFFICIENT TO REQUIRE AMPUTATION?
☐ YES ☐ NO

IF INJURY RELATED TO LOSS OF SIGHT (EYE) Please answer the following (nos. 17-23) in addition to nos. 1-12.

(17) IS THERE, IN THE INJURED EYE(S) ANY PERCEPTION OF:
LIGHT ☐ YES ☐ NO OBJECTS ☐ YES ☐ NO

(18) IS THE LENS OF EACH EYE INTACT?
☐ YES ☐ NO

(19) WHAT DEGREE OF VISION NOW PRESENT IN:
RIGHT EYE: LEFT EYE:

(20) WHAT TESTS WERE USED TO DETERMINE DEGREE OF VISION?

(21) WHAT IS THE CONDITION OF PUPILLARY REFLEXES?
RIGHT EYE: LEFT EYE:

(22) IS THERE TOTAL BLINDNESS IN INJURED EYE? IF SO, ON WHAT DATE DID YOU DIAGNOSE TOTAL LOSS OF SIGHT?
☐ YES ☐ NO DATE: ______________

(23) IS LOSS OF SIGHT IRRECOVERABLE?
☐ YES ☐ NO

DATE: ______________________

Telephone: ______________________
(AREA) (NO.)

SIGNED: ______________________
Attending Physician

Address: ______________________

____
(CITY) (STATE) (ZIP)

PROOF OF LOSS OF LIMB(S) OR SIGHT STATEMENT

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INSTRUCTIONS

INSURED: 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 Insured immediately after the accident. Have Attending Physician complete Part IV (STATEMENT OF ATTENDING PHYSICIAN). Then return form to your Employer for completion of part III (STATEMENT OF EMPLOYER).