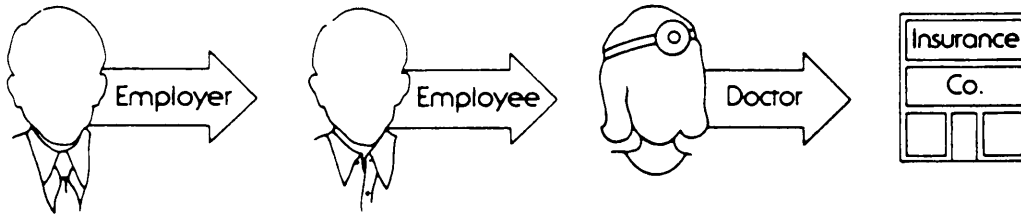


Group Waiver of Premium/Extended Death Benefit **CLAIM**

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 9 months after last day worked, but before 12 months.

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

Include:

- *Copy of Enrollment Card*

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

C. *Include:*

- *Copy of Claimants Birth Certificate*
- *Summary of Training, Education and Experience*

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

- E. *All portions of this form package must be completed to avoid undue delay in processing.*



LIFE INSURANCE COMPANY

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

APPLICATION FOR WAIVER OF PREMIUM/EXTENDED DEATH BENEFIT

ADMINISTRATOR'S OR EMPLOYER'S STATEMENT			
Name of Employee		Social Sec. No.	Date of Birth
(First Name)	(Middle Initial)	(Last Name)	
Home Address			
(Street)		(City)	(State) (Zip Code)
Job Title	Amount of Insurance	Annual Salary or Pension	Name of Employer
Date First Entered Our Employ	Date Last Worked	Reason for Stopping Work	

LIST, IN ORDER OF IMPORTANCE, ALL DUTIES NORMAL TO THE JOB			
JOB	DESCRIPTION OF DUTY	% OF TIME DEVOTED TO THIS ACTIVITY	HOURS SPENT AT THIS ACTIVITY

Physical Requirements: _____

Comments: _____

DATE	SIGNATURE	TITLE

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

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient		Date of Birth				
HISTORY	(a) When did symptoms first appear or accident happen?		(b) Date patient ceased work because of disability?		(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If "Yes", state when and describe.</small>	
	(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			(e) Names and addresses of other treating physicians		
DIAGNOSIS	(a) Diagnosis (Including complications)		(b) If pregnancy, est. date of delivery		(c) Subjective symptoms	
	(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)					
TREATMENT	(a) Date of first visit		(b) Date of last visit		(c) Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)	
	(d) Nature of treatment (Including surgery and medications prescribed, if any)					
PROGRESS	(a) Has patient? <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?		(b) Is patient? <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> Hospital Confined?			
	(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give Name and Address of Hospital Confined from _____ through _____			
CARDIAC	(a) Functional Capacity (American Heart Association) <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)			(b) Blood Pressure (Last Visit) _____ / _____ Systolic/Diastolic		
	(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles) <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	(b) Mental Impairments (If Applicable)					
	(a) Please define "stress" as it applies to this claimant. (b) What stress and problems in interpersonal relations has claimant had on job? <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: _____					
PROGNOSIS	(a) Is patient now totally disabled?		PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Date patient became disabled due to present illness	
	(c) When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 – 6 Months <input type="checkbox"/> Never <input type="checkbox"/> 1 – 3 Months					
REHAB	(a) Is patient a suitable candidate for occupational rehabilitation?		PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	(c) When could trial employment commence? 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	(Limitations, Therapy, etc.)					
Name (Attending Physician) Print		Degree		Telephone		
Street Address		City or Town		State or Province		
Signature		Date				



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 or Government 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.

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.