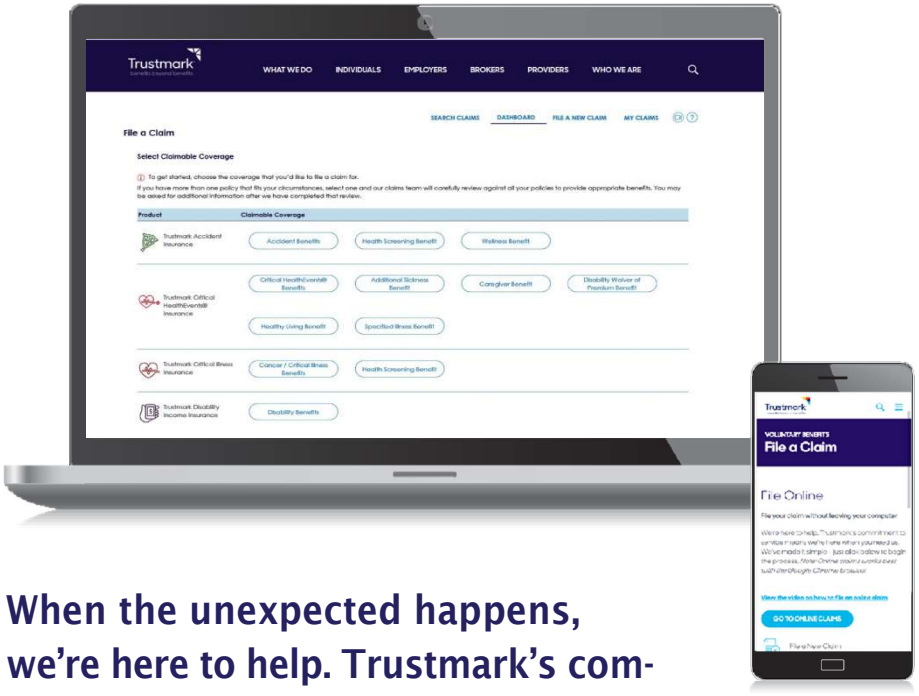
We've made it simple – you can file your Voluntary Benefits claim online.



When the unexpected happens, we're here to help. Trustmark's commitment to service means we're here when you need us.

TrustmarkVB.com/Claims

Trustmark
benefits beyond benefits

A112-2574 (2-20)

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Claim Submission Instructions and Supporting Documentation

Please be sure to review the requirements noted below for claim submission and ensure your submission is complete to avoid any delays on your claim.

Please keep a copy of all parts of this form and any supporting documentation for your records.

The following information must be supplied:

- **A fully completed claim form.** Please note incomplete or illegible answers may result in a delay in processing benefits.
- **Section A, & B –** *To be completed by Policy Owner.* Complete these sections in full and return for review of benefits. If you need more space, please include additional pages with your responses.
- **Disclosure Authorization -** *To be completed by Insured(Patient) (or Policy Owner, if Insured/Patient isunder 18 or legally incapacitated.)*
  - Be sure to sign and date this section of the form, including DOB & Social Security Number (SSN) where indicated
  - If a Power of Attorney, Guardianship, or similar appointment is in place, this individual should complete Section C of the Disclosure Authorization
- **Claim Submission Signature** – *To be completed by Policy Owner.* Be sure to sign and date this section of the form.
- **Employer Statement** - *To be completed by Patient's Employer.*
- **Attending Physician Statement** – *To be completed by the Physician primarily responsible for the patient's care.* Please be sure that all dates of treatment are indicated in this section and that the physician signs and dates the form.

Optional:

- **E-Sign Disclosure and Consent Notice** – *This section of the claim form is not required but completing it will provide better and faster communication with you or anyone you designate. Complete if you would like claim communication by text or email, including text alerts for payments released. It should be completed by each Beneficiary, Executor and/or Administrator who would like to receive communication. If not completed, please note default communication will be written and sent via USPS.*
- **Third Party Communication Authorization** – *To be completed by Policy Owner & Patient.* Complete if you would like to authorize Trustmark to release information on your claim(s) to a third party such as a spouse, friend or agent.

Informational:

- **State Required Fraud Language –** These sections of the claim form provide important information about your rights and the laws in each state.

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Section A – Insured's Information *(To Be Completed by Insured)*

Policy / Certificate #: _____

Name: _____ DOB: _____ SSN: _____

Address: _____
Street City State Zip Code

Phone # _____ Home Cell Work E-Mail Address: _____

Name & Address of Employer: _____ Date Employed _____

Occupation: _____ Principal Duties: _____

Employee of Trustmark Companies? Yes ☐ No ☐ Language Preference: English ☐ Spanish ☐

Section B – Claim Information *(To Be Completed By Insured)*

Doctors Consulted		
Name	**Address**	**Dates**

Describe nature of illness or injury: _____

1. If ***Illness,*** on what date did you first notice the illness? _____
2. If ***Accident/Injury***, date occurred? _____ Were you at work? Yes ☐ No ☐

How did accident/injury happen? _____

3. Date you stopped working due to disability: _____
4. Date you resumed any work activity: _____
5. If you are not currently performing any work activity, what date do you expect to be able to return to work full or part time? _____
6. Please indicate any benefits that you are eligible to receive:

Source	Amount	Date Applied	Date Payments Began	Date Payments End
State Disability	$			
Social Security	$			
Worker's Comp	$			
Unemployment	$			
Retirement/Pension	$			
Other_____	$			

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Section B – Claim Information (Continued) *(To Be Completed by Insured)* **Policy #:** _____

Please provide the following information concerning your education, prior occupations, hobbies, special skills, and interest in future employment.

	Question	Response
Education	What is the level of your education? How many years of grade school, high school, college, etc.?	
	Describe courses taken (commercial, vocational, academic, etc.) Any trade schools, military training schools, or other special training? If so, please describe.	
	Are you currently enrolled or attending classes or training toward a certificate, degree, continuing education requirement or certification?	
Prior Occupations	Attach resume or list & give details of all previous occupations for the prior 10 years. Specify ***all duties of each occupation*** and show beginning & end dates of employment (add additional sheets of paper if needed).	
Special Skills and Abilities	Identify equipment, tools, and machinery that you have used or operated in the past.	
Hobbies	Do you have any hobbies and/or other special interests (woodworking, mechanical repairs, painting, etc.)? If so, please describe in detail.	
Occupational Interests	Would some other employment interest You based on your past experience, hobbies, special training, etc.? If so,please describe in detail.	
Resuming Work	Have you participated in any type of work since your disability began? If so, givedetails including the type of work, theduties performed, when and where your work activity took place, includingemployer(s) name and address.	
Vocational Rehabilitation	Are you participating in a rehabilitation program? Yes ☐ No ☐ If ***Yes***, please describe details of the program.	

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

E-Sign Disclosure and Consent Notice

This E-Sign Disclosure and Consent Notice ("Notice") applies to all communications, as defined below, for services provided by Trustmark Companies and our affiliates ("Trustmark" or "We"). Under this Notice, communications you receive in electronic form from us will be considered "in writing."

By using Trustmark electronic and online services ("Electronic Services"), you acknowledge that your electronic signature is legally binding and shall be treated as a valid signature for all purposes.

In addition, by using Trustmark Electronic Services you consent to the entirety of this Notice and affirm that you have access to the hardware and software requirements identified below. You must review and accept the terms of these services. If you choose not to consent to this Notice or you withdraw your consent, you will be restricted from using Electronic Services.

PREFERRED METHOD OF COMMUNICATION

☐ Text Messages and Email - Please provide cell phone #: _____

☐ Email Only - Please confirm email address: _____@ _____

You should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lackof security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents, have access to electronic communication between you and us.

You understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Trustmark and I assume responsibility for any costs associated with these text messages. Thisconsent shall remain in effect unless revoked by notifying Trustmark.

COVERED COMMUNICATIONS

Includes, but is not limited to disclosures or communications we provide to you regarding our services such as: (i) claim submissions, third party authorizations, overpayment authorizations, fraud notices, terms and conditions, privacy statements or notices and any changes thereto; and (ii) customer service communications(such as claims of error communications) ("Communications").

METHODS OF PROVIDING COMMUNICATIONS

We may provide Communications to you by email or by making them accessible on the Trustmark websites, mobile applications, or mobile websites (including via "hyperlinks" provided online and in e-mails). Communications will be provided online and viewable using browser software or PDF files.

HARDWARE AND SOFTWARE REQUIREMENTS

To access and retain electronic Communications, you must have:

- A valid email address;
- A computer, mobile, tablet or similar device with internet access and current browser software and computer software that is capable of receiving, accessing, displaying, and either printing or storing Communications received from us in electronic form;
- Sufficient storage space to save Communications (whether presented online, in e-mails or PDF) or the ability to print Communications.

We may request that you respond to an email to demonstrate you are able to receive these Communications.

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service:	**Phone:** (877) 201-9373 x45750
For Claims Submission:	**Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
	Mail: P.O. Box 2906 Clinton, IA 52733

HOW TO WITHDRAW YOUR CONSENT

You may withdraw your consent to receive Communications under this Notice by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733." Your withdrawal of consent will cancelyour agreement to receive electronic Communications, and therefore, your ability to use our Electronic Services.

REQUESTING PAPER COPIES OF ELECTRONIC COMMUNICATIONS

You may request a paper copy of any Communications; we will mail you a copy via U.S. Mail. To request a paper copy, contact us by writing to "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906 Clinton, IA 52733-2906. " Please provide your current mailing address so we can process this request. Trustmark may charge you a reasonable fee for this service.

UPDATING YOUR CONTACT INFORMATION

It is your responsibility to keep your primary email address current so that Trustmark can communicate with you electronically. You understand and agree that if Trustmark sends you a Communication but you do not receiveit because your primary email address on file is incorrect, out of date, blocked by your service provider, or you are otherwise unable to receive electronic Communications, Trustmark will be deemed to have provided the Communication to you; however, we may deem your account inactive. You may not be able to transact usingour Online Services until we receive a valid, working primary email address from you.

If you use a spam filter or similar software that blocks or re-routes emails from senders not listed in your email address book, we recommend that you add Trustmark to your email address book so that you can receive communications by e-mail.

You can update your primary email address or other information by writing to us at "Attn: E-Sign Disclosure and Consent Notice, P.O. Box 2906, Clinton, IA 52733.

FEDERAL LAW

You acknowledge and agree that your consent to electronic Communications is being provided in connection with a transaction affecting interstate commerce that is subject to the federal Electronic Signatures in Global and National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct business with you by electronic means.

TERMINATION/ CHANGES

We reserve the right, in our sole discretion, to discontinue the provision of your Communications, or to terminateor change the terms and conditions on which we provide Communications. We will provide you with notice of any such termination or change as required by law.

Authorization

I can revoke or update this authorization at any time by notifying Trustmark. This authorization is valid for 24 months. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____

Policy Owner or Beneficiary Signature ***Date Signed***

_____ _____

Printed Name ***Daytime Phone Number***

Residence Address:

_____

Street City State Zip Code

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

State Required Fraud Language

Fraud Statement for the states of Alaska, Delaware, Indiana, Kentucky, Minnesota, Ohio, and Oklahoma, as well as for all States not Specifically Listed: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud, which is a crime."

Fraud Statement for the state of Arizona: For your protection, Arizona law requires the following statement on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud Statement for the states of Arkansas, Louisiana, New Mexico, Rhode Island, Texas and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for the state of California: For your protection, California law requires the following to appear: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Statement for the state of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting todefraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Statement for the District of Columbia, and the states of Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Fraud Statement for the state of Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for the state of Kentucky: A 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 commits a fraudulent insurance act, which is a crime.

Fraud Statement for the state of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for the state of New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Fraud Statement for the state of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Statement for the state of New York: Any person who knowingly and with intent to defraud any insurance company or other person files any application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In New York, civil penalty shall not exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Statement for the state of Oregon: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing materially false or misleading information may be guilty of insurance fraud.

Fraud Statement for the state of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files any application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

DISCLOSURE AUTHORIZATION

Insured's Name(Patient)(*Please Print***):**_____**SSN#**_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration, or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings, credit history or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS), driving records, credit reports, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Administration to release information or records about me to Trustmark Insurance Company or its authorized representatives. Such release of Social Security information will be used to adjudicate my claim in accordance with my policy benefits, or to continue my eligibility for benefits. I further request that the Social Security Administration release detailed earnings for up to the last ten years and/or a summary record of total earnings and/or information from master benefit records regarding award, denial or continuing Social Security benefits.

I understand that I may revoke this authorization at any time. Any such revocation is to be in writing, signed and dated by me, and must be forwarded directly to Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to me. A photocopy of this Authorization is as valid as the original and I (or my authorized representative) may request a copy. I understand that I may request a copy of any credit report Trustmark receives in connection with this authorization. This Authorization will be in force for the duration of the claim or up to 12 months from the date shown, whichever time period is less. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim, including denial of benefits under my policy. I understand that there is a possibility of redisclosure of information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that I may request a record of redisclosure of any information.

Patient Signature (or Policy Owner, if Patient is under 18): _____

Signed by: Policy Owner ☐ Patient ☐ Date Signed:_____ Patient's Date of Birth: _____

Relationship, if other than insured: _____

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Third Party Communication Authorization

Please complete this authorization if you would like us to discuss, to release, or to provide information to a third party regarding any policy and/or claim for benefits under your policy. Note: Policy Owner and Claimant (if appropriate) must give permission for disclosure of their information to each other, if applicable.

Policy Owner Name:_____

Claimant Name: _____

Policy Number(s): _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

Name & Relationship of Third Party Representative: _____

□ All information (all policy and claim information)

□ Only the following information*: _____

□ **My Agent: (Name of Agent)** _____

□ All information (all policy and claim information)
□ Only the following information*: _____

□ **My Employer: (Name of Agent)** _____

□ All information (all policy and claim information)
□ Only the following information*: _____

*Restrictions may include a restriction on certain types of information (such as not sharing financial, medical or health information).

I agree that if I authorize release of all policy and/or claim information this may include health information which may be related to disorders of the immune system including but not limited to HIV and AIDS, use of alcohol or drugs, mental and physical condition, history, or treatment.

I understand that any information shared may be subject to re-disclosure and might not be protected by certain federal or state regulations governing the privacy of health information relative to my condition.

I may revoke and update this authorization in writing at any time or by email to address noted above. I understand that this authorization is valid until my revocation or until I complete a new authorization. Any new authorization will effectively revoke this authorization and replace it.

_____ _____
Signature of Policy Owner | Signature of Claimant (If someone other than the Policy Owner)

_____ _____
Printed Name | Printed Name

_____ _____
Date | Date

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Claim Submission Signature

The statements made by me on this claim are true and complete. I have read and understand the fraud notices contained in this form.

If I receive benefit payments greater than those which should have been paid, I understand that I will be requested to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminatefuture benefit payments, to the extent allowed by law, in order to recover any overpayment balance that is not returned.

Fraud Statement for the state of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Signature of Policy Owner: _____ Print Name: _____

Date signed: _____

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Employer Statement

The below portion of this statement must be completed by the Supervisor / Human Resource Contact of the employer for the patient. If the patient is self-employed, the patient must complete the following statement in full.

Name of Employee: _____

Employer Name: _____

Employer Address: _____

Job Title: _____

Job Classification(please check): Heavy Labor ☐ Moderate Labor ☐ Light Labor ☐ Sedentary/Clerical ☐

Job Duties *(Please attach a job description. If no job description is available, please list job duties below)*:

_____

_____

_____

_____

Hours worked during the week: _____

Yearly earnings: Total $_____ Base: $_____ O/T: $_____

Date employee last worked: _____ If terminated: Date _____

Reason Not Working *(please check)*:

Sickness ☐ Injury ☐ Retired ☐ Resigned ☐ Dismissed ☐ Laid Off ☐

Other: _____

Were job duties modified or hours reduced due to illness or injury prior to last day worked: Y ☐ N ☐

If yes, please describe: _____

Date employee returned to Regular Duties: FT:_____P/T:_____

Date employee returned to Light Duties: FT:_____P/T:_____

Occupation employee returned to: _____

Has not returned to work- Yes ☐ or No ☐

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Supervisor/Employer Human Resource Signature: _____

Printed Name:_____ Title: _____

Date Signed:_____ Telephone: _____Fax: _____

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement *(To be completed by Attending Physician of patient)*

Name of Patient:_____Date of Birth: _____

1. **In the past 36 months did the patient smoke or use tobacco products: Yes ☐ No ☐**
2. **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? Yes ☐ No ☐ If Yes, state when and describe details:
   _____
   d. Names & addresses of other treating physicians: _____
   _____
3. **Diagnosis** *(Including any complications)*
   a. Diagnosis: _____
   b. Subjective Symptoms: _____
   _____
   c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)
   _____
4. **Dates of Treatment**
   a. Date of 1st visit? _____ b. Date of last visit? _____
   c. Frequency of visits? Weekly ☐ Monthly ☐ Other: ☐ _____
5. **Provide Nature of Treatment** *(Including surgeries, if any)*

_____
_____
_____
_____
_____
_____
_____
_____

Will treatment substantially improve functionality and employability? Yes ☐ No ☐

6. **Current Medications** (Including dosage and frequency)

_____ Dosage_____Frequency_____
_____ Dosage_____Frequency_____
_____ Dosage_____Frequency_____
_____ Dosage_____Frequency_____

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement – (Continued) *(To be completed by Attending Physician of patient)*

Name of Patient:_____Date of Birth: _____

7. Physical Impairment *(Check One)*

☐ **Class 1** – No limitations of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)

☐ **Class 2** – Slight limitation of functional capacity; capable of light manual activity. (15-30%)

☐ **Class 3** – Moderate limitation of functional capacity; capable of clerical/administrative activity (Sedentary). (35-55%)

☐ **Class 4** – Marked limitation. (60-70%)

☐ **Class 5** – Severe limitations of functional capacity

Remarks: _____

_____

8. Mental / Nervous Impairment *(If applicable)*

☐ **Class 1** – Patient is able to function under stress and engage in interpersonal relations. ***No limitations***

☐ **Class 2** – Patient is able to function in most stress situations and engage in most interpersonal relations. ***Slight limitations***□

☐ **Class 3** – Patient is able to function in only limited stress situations and engage in only limited interpersonal relations. ***Moderate limitations***□

☐ **Class 4** – Patient is unable to engage in stress situations or engage in interpersonal relations. ***Marked limitations***□

☐ **Class 5** – Patient has significant loss of psychological, physiological, personal and social adjustment. Severe limitations

Remarks: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?

Yes ☐ No ☐

8. Prognosis	**Patient's Job**		**Any Other Work**	
Is patient now totally disabled?	Yes ☐ No ☐		Yes ☐ No ☐	
Do you expect a fundamental or marked change in the future?	Yes ☐ No ☐		Yes ☐ No ☐	
If **YES,** when will patient recover sufficiently to perform duties?	_____	1 Mo ☐ 1-3 Mos ☐ 3-6 Mos ☐ Never ☐	_____	1 Mo ☐ 1-3 Mos ☐ 3-6 Mos ☐ Never ☐
If **NO**, please explain:				
Date released to work:	_____		_____	

Trustmark
benefits beyond benefits

Application for Waiver of Premium

For Claims Customer Service: **Phone:** (877) 201-9373 x45750
For Claims Submission: **Fax:** (508) 853-0310 **Email:** LifeClaimsVB@trustmarkbenefits.com
Mail: P.O. Box 2906 Clinton, IA 52733

Attending Physician Statement – (Continued) *(To be completed by Attending Physician of patient)*

9. Remarks

Are you, the physician, related to this patient? Yes ☐ No ☐ If yes, what is the relationship? _____

May we communicate with you via email? Yes ☐ No ☐ If yes, Email Address: _____

Physician's Name: (please print): _____ Specialty: _____

Address: _____

Phone: _____ Fax: ____ _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Physician's Signature:_____ Date Signed: _____

**** Please attach copies of all medical records relating to the claimed condition including treatment notes and test results.***

*** If you require your own Disclosure Authorization to release information, please provide it directly to the patient.*