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.*