Trustmark
benefits beyond benefits

Early Benefits - Life Claim

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's Statement *(To be completed by the Attending Physician)*

Name of Patient:_____Patient's Date of Birth: _____

Please state diagnosis: _____

In the past 36 months did the patient smoke or use tobacco products: Yes ☐ No ☐

Describe nature & cause of injury or condition: _____

Date of symptoms first occurred: _____ ICD Code: _____

Date of first treatment for this condition: _____ Frequency of treatment: _____

Type of treatments provided:_____

_____

List of current medications: _____

_____

Is patient hospitalized? Yes ☐ No ☐ If yes, give dates: _____

Hospital Name(s): _____

Hospital Address: _____
Street City State Zip Code

Hospital Telephone#_____

Name of Referring Physician (if applicable):_____

Address: _____
Street City State Zip Code

Prognosis: _____

After a thorough, extensive medical review, I have concluded that_____is terminally ill

and is anticipated to only survive the next_____months.

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 name (please print)_____Specialty_____

Phone:_____Fax:_____ Email: _____

Address: _____
Street City State Zip Code

Signature_____Date: _____