INSTRUCTIONS

Complete *Part I – Statement of the Insured* of this claim form.
The Policy Owner must sign and date the authorization.
Have the physician complete the *Attending Physician's Statement*.
The Insured/ Claimant, Spouse and/or Owner must complete the *Signatures Required* portion of the claim form.

Trustmark Life Insurance Company of New York
126 South Swan Street, Suite 203, Albany, NY 12210 ACCELERATED DEATH BENEFIT CLAIM FORM

PART 1 - STATEMENT OF THE INSURED

Name of Insured

Address

Social Security Number | Occupation | Date of Birth

Current Illness | Date of Diagnosis

Physician's Name

Physician's Address

If hospitalized within the last five years, list hospitals | Date Admitted

Hospital's Address

Employer's Name | Address

Note: Accelerated Death Benefit not available if policy is assigned: proper release documents should accompany this form.

If policy is assigned, give name and address of assignee | Amount of Assignee Claim

Address

The following disclosure is made pursuant to the Fair Credit Reporting Act:
Please be notified that, as a result of our regular claims investigation procedures, an investigative consumer report may be prepared, whereby information received from third parties is obtained from an independent inspection company. You have the right to make a written request within a reasonable period of time to receive detailed information about the nature and scope of this investigation.

Authorization:
I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, Veterans Administration or government agency to furnish all information and copies of records regarding health care or treatment provided me, including, but not limited to, admitting records, hospital records, test records, finding and diagnostics. Such information and records shall be provided to a representative of the Claim Department of Trustmark Life Insurance Company of New York. The information obtained by this authorization is for use solely to determine my eligibility for insurance benefits. This authorization includes information about mental illness.

I authorize my present or past employer(s) to supply information covering the status of my employment, job duties, days absent from work and training provided. This information may be provided to a representative of Trustmark Life Insurance Company of New York and is to be used solely to determine my eligibility for insurance benefits. Any information obtained will not be released by Trustmark Life Insurance Company of New York to any person or organization.

I further authorize Trustmark to release all copies of medical records collected during its investigation to a second physician (and third, if required).

I further authorize this statement to be copied and the copy utilized as if it were an original.

I understand that upon request I have a right to obtain a copy of this authorization.

I understand this authorization will remain valid for one year from this date.

I understand that failure to sign this authorization may delay the payment of my claim.

Insured's Signature | Date Signed

Attending Physician's Statement (I)

Name of Patient _____ Patient I.D. Number _____

Please state diagnosis: _____

Describe nature and cause of injury or condition: _____

Date symptoms first occurred: _____

Has patient had same or similar condition? ☐ Yes ☐ No. If yes, when? _____

If no, what are the contributing factors? _____

List all dates of treatment: _____

List all prescribed treatment: _____

List present medications: _____

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

Hospital Name(s) _____

Address(es) _____ Telephone Number(s) _____

Name of Referring Physician (if applicable) _____

Address _____

Prognosis _____

After a thorough, extensive medical review, I have concluded that _____ is terminally ill and is anticipated to only survive the next _____ months.

Physician's Signature _____ Date Signed _____

Physician's Address, City, State, ZIP _____

Physician's Phone Number _____

Physician (II)

I have reviewed _____case and medical records.

I concur with Dr. _____on the prognosis.

A copy of my medical evaluation is attached.

Physician's Name _____

Address _____

Signatures Required

I have read the statements on this form and concur with them. I am of sound mind and have advised my beneficiaries, the executor of my estate, and my attorney of my action and have instructed that I alone am responsible for seeking this benefit.

New York regulation requires Trustmark Life Insurance Company of New York to provide you with the following notices and statements: Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse and dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.

By signing this claim form you declare that your application for this benefit is voluntary and without coercion on the part of any third party.

No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Within 5 days of receiving your request that you may want to claim the accelerated death benefit, Trustmark Life Insurance Company of New York is required to provide you with: 1) a numerical computation of the amount of the death benefit You requested for acceleration, and the amount to be paid in cash; 2) the amount of your death benefit if you chose not to accelerate it; 3) an illustration demonstrating the effect of the accelerated death benefit requested on the policy's face amount, death benefit, premium payments, accumulation account, cash value, loan balance, and partial withdrawals as provided under the terms of the policy. Trustmark Life Insurance Company of New York is prohibited from paying accelerated death benefits to you for 14 days from the date on which this information is transmitted to you in writing. Trustmark Life Insurance Company of New York reserves the right to charge an administrative fee of up to $250.

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.

New York Regulation requires that this claim form must be completed and signed by Policyowner within 30 days from the date Trustmark Life Insurance Company of New York transmitted this claim form.

Date of Transmittal: _____

Completed Claim Form should be returned to: Trustmark Life Insurance Company of New York, PO Box 7962, Lake Forest, IL 60045-7962

_____

Insured/Claimant Date

_____

Spouse Date

(If a Community Property state, I hereby forever waive all community property right and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner.)

Owner (if other than insured) Date

Joint Owner (if applicable) Date

Irrevocable Beneficiary Date

(if applicable, I hereby forever waive all rights and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner.)

Notarized Signature Date