Trustmark Life Insurance Company of New York

Administrative Office
PO Box 7962
Lake Forest IL 60045-7962

Phone: 866-949-6036 • Fax: 847-615-3132
Email: TrustmarkNY@trustmarkinsurance.com
Website: http://www.trustmarkinsurance.com/customersolutionsny

CONTINUANCE WAIVER OF PREMIUM CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for the completion of this form without expense to the Company.
Please answer all of the questions pertaining to current disability.

Patient's Name _____ Date of Birth _____/_____/_____ Policy Number _____

Address _____
Street City State Zip

1. HISTORY

(a) When did symptoms first appear or accident happen?..... Mo. _____ Day _____ 20 _____
(b) Date patient ceased work because of disability..... Mo. _____ Day _____ 20 _____
(c) Has patient ever had same or similar condition..... Yes ☐ No ☐ If "Yes" state when and describe.

(d) Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐ Unknown ☐
(e) Names and addresses of other treating physicians.

2. DIAGNOSIS (Including any complications)

(a) Diagnosis:
(b) Subjective symptoms

(c) Provide objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

(a) Date of first visit..... Mo. _____ Day _____ 20 _____
(b) Date of last visit..... Mo. _____ Day _____ 20 _____
(c) Frequency..... Weekly ☐ Monthly ☐ Other (Specify) ☐ _____

4. PROVIDE NATURE OF TREATMENT (including Surgery and medications prescribed, if any)

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

5. PROGRESS

(a) Has patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐
(b) Is patient Ambulatory? ☐ House confined? ☐ Bed confined? ☐

6. CARDIAC (if Applicable)

(a) Functional capacity Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐
(American Heart Ass'n) Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) ☐

(b) Blood Pressure (last visit)..... _____ / _____
SYSTOLIC DIASTOLIC

7. PHYSICAL IMPAIRMENT (CHECK ONE)

- ☐ Class 1 - No limitation 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 (sedentary) activity. (35-55%)
- ☐ Class 4 - Marked limitation. (60-70%)
- ☐ Class 5 - Severe limitation 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 engage 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

9. PROGNOSIS

	PATIENT'S JOB	**ANY OTHER WORK**
(a) Is patient now totally disabled?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you expect a fundamental or marked change in the future?	Yes ☐ No ☐	Yes ☐ No ☐
(1) If yes, when will patient recover sufficiently to perform duties?	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.
	1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ Never ☐	1 Mo. ☐ 3 Mos. ☐ 3-6 Mos. ☐ Never ☐

(2) If no, please explain:

(3) Date released to work own job: ____/____/____ Mo. Day Yr. **Date released to work any job:** ____/____/____ Mo. Day Yr.

10. REHABILITATION

	PATIENT'S JOB	**ANY OTHER WORK**
(a) Is patient a suitable candidate for trial employment?	Yes ☐ No ☐	Yes ☐ No ☐
(1) If yes, when could trial employment commence?	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.
	Full-time ☐ Part-time ☐	Full-time ☐ Part-time ☐

(2) If no, please explain:

(3) If yes, what training will patient require?

11. REMARKS

Signature (Attending Physician) | Degree | Date | Telephone

Street Address | City | State | Zip

DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____

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 Life Insurance Company of New York and affiliates or its employee and agents, or any other 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 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, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Life Insurance Company of New York or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Life Insurance Company of New York. I AGREE the information obtained with this Authorization may be used by Trustmark Life Insurance Company of New York and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. 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 any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Life Insurance Company of New York and affiliates to report to ICS, any dates of past or present claims filed by me.

Resident of NY – 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 or each such violation.

Date: _____ Signature: _____

Date of Birth_____/_____/_____ Relationship if other than insured:_____