Trustmark
benefits beyond benefits

Death Benefit Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45750
For Claims Submission: 🖷 **Fax:** (508) 853-0310 ✉ **Email:** LifeClaimsVB@trustmarkbenefits.com

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

Deceased's Full Name: _____ Date of Birth: _____

How long have you treated the deceased? _____

Date of death? _____ Place of death: _____

When you were first consulted for the condition which directly or indirectly caused death:_____

Immediate cause of death? _____ Duration: _____

Contributory cause of death: _____ Duration: _____

Other chronic diseases, conditions or impairments:_____ Duration: _____

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

Please give particulars of any condition, chronic disease or impairment for which you treated or advised deceased prior to last illness

Disease or Condition	Date	Duration	Result

Please give name & addresses of all other physicians or other practitioners who attended deceased within the five years preceding death

Physician Name	Address	Phone	Disease or Condition

Names of any medications prescribed for deceased within the five years preceding death

Medication Name	Reason Prescribed	Pharmacy Where Filled

Physician's name (please print)_____ Specialty_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Address: _____
Street City State Zip Code

Signature_____ Date _____