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

Attending Physician Statement *(To be completed by Attending Physician of patient)*

Name of Patient: _____ Date of Birth: _____

1. **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: _____
   _____
2. **Diagnosis** *(Including any complications)*
   a. Diagnosis: _____
   b. Subjective Symptoms: _____
   _____
   c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)
   _____
3. **Dates of Treatment**
   a. Date of 1st visit? _____ b. Date of last visit? _____
   c. Frequency of visits? ☐ Weekly ☐ Monthly ☐ Other: _____
4. **Provide Nature of Treatment** *(Including surgeries, if any)*

_____
_____
_____
_____
_____
_____
_____
_____

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

5. **Current Medications** (Including dosage and frequency)

_____ Dosage _____ Frequency_____
_____ Dosage _____ Frequency_____
_____ Dosage _____ Frequency_____
_____ Dosage _____ Frequency_____
_____ Dosage _____ Frequency_____

Please continue on next page

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

Attending Physician Statement – (Continued) *(To be completed by Attending Physician of patient)*

Name of Patient: _____ Date of Birth: _____

6. 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: _____

_____

7. 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:	_____		_____	

Please continue on next page

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

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: (____) _____

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.*