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

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

Name of Patient: _____ Patient Date of Birth: : _____

Please state diagnosis: _____

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 treatment provided: _____

List current medications: _____

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

Hospital Name(s): _____

Hospital Address: _____
Street City State Zip Code

Phone #_____

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.

Physician's name (please print)_____ Specialty_____

Phone: _____ Fax: _____

Address: _____
Street City State Zip Code

Signature_____ Date _____