TRUSTMARK LIFE INSURANCE COMPANY, LAKE FOREST, ILLINOIS GROUP INSURANCE EVIDENCE OF INSURABILITY NOTE: NOT TO BE USED FOR MEDICAL OR DENTAL COVERAGE

Please type or print in ink only

	GROUP POLICYHOLDER	INFORMATION (To be complete	d by Benefi	ts Administra	ator)		
	Name of Group Policyholde Division Number				G	roup Number		
	Benefits Administrator Name				Phone Number ()			
	Benefits Administrator Addr					, ,		
			Street		City	State		Zip Code
	Employee Name		Social Security No			Date of Hire		
	Occupation							
	Employee's Address						Marital S	Status
	Stree		City	State	•			
<u>.</u> .	COVERAGE BEING APPLI	ED FOR THE FO	LLOWING (cnec	k ali that app				
		Employee	Spouse Child(ren)		HOME OFFICE USE ONLY Approve Decline			
	Life/AD&D		•	\$				
	Optional Life/AD&D			\$				
	Supplemental Life/AD&D	\$	\$	\$				
	Short Term Disability							
	Long Term Disability							
	Other							
	Effective Date of Coverage: Underwriter: Date: _							
		REAS	SON FOR EVIDE	NCE APPL	ICATION			
3.	Late Enrollee Ex	cess Life	Required by Plai	n (explain) _		(Other _	
١.	EMPLOYEE INFORMATION	N (To be comple	ted by employe	e)				
	Complete for each person	•		•		Data of	F11 43	Ob - db
	Name	Relationship	Male/Female	Height	Weight	Date of Birth	Full-II Y	me Student es/No
		Self						
		Spouse						
		Child						
		Child						
		Child						
			l	Lad Carrier		-1-1		. C. II.
٠.	Has any person proposed f	or coverage ever	nad or been trea	ited for or co	nsuited a pny	sician about ar	ny of the YES	e following: NO
							120	110
	A. Epilepsy, brain or nervo	-						
	B. Respiratory or lung discC. Diabetes, kidney disord		•		nitis, emphyse	ma?		
	D. Stomach, intestine, rec	-	-		pendix, liver o	or		
	gall bladder disorder, he			. I I				
	 E. Arthritis, lupus, rheuma muscle or joint disorder 	-	k spine or skeieta	ai system dis	soraer, bone			П
	F. Cancer, tumor, growth		hyroid disorder?					
	G. Congenital defect or dis		•	مامامين مادانات		J:		
	 H. Disorder of the reproductions of pregnations 	-	reast disorder, le	runty probler	ns, venerear c	iisease,		
	I. Impairment in sight, spe	eech or hearing, o	•					
	 J. Heart or circulatory sys murmur, rheumatic feve 	_	h blood pressure	, chest pains	s, stroke, hear	t		
	K. Alcoholism, drug deper		nce abuse?					
3.	Has any person proposed	for coverage beer	n diagnosed by a		•			
	having disorder of the bloof for exposure to HIV infection	-	n or lympn nodes	s including A	טטוא, or tested	i positive		
7.	To the best of your knowled	dge, other than a					_	
	application is being made i							
	by a medical practitioner, u in the past 5 years?	nuergone a surgi	cai procedure or	been nospit	aıızed (INCIUdi	ng pregnancy)		
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							Yes	No											
8. Do you or anyone proposed for coverage plan to visit a medical practitioner or have an operation								П											
 for any existing injury or illness? 9. During the past 12 months have you or any proposed insured had any medical consultation, advice or treatment by a medical practitioner, had medication prescribed, had surgery, or been confined in a hospital, psychiatric or school and drug dependency facility (inpatient or outpatient), or been advised by a medical practitioner, that a hospital confinement, and/or surgery will be needed during the next 6 months? 10. Has any person proposed for coverage ever been declined, postponed, rated or limited for life or health insurance? 																			
										11. Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months? If yes, amount per day ; and for how long .									
										12. Is an	y person pro	oposed for coverage i	-	,	<u> </u>		П	П	
For any o		nswered "YES" in i	tems #5 through 10,	please su	ipply the fo	ollowing information	, and b	e as											
Question Number		Condition, Injury or S	Condition, Injury or Symptom of III Health (Name of Operation Performed)		Date Last Treated	Results/Pro (List Current Medicatio	•												
of insurar	nce under w		AGREEME cation are true and corrected recoverage. I understate the office.	omplete. I a															
			ompleted application a erage under the contr		that any fa	lse statements or mis	represe	entation											
medical r institution information Trustmark make such A copy of Any person	related faciling or person to person to person to person to person to person to person the person to person the person to pers	ty; (3) any insurance hat has data on me of older drug abuse an nce Company. I waive behalf of myself and a e as valid as the originally and with intent	ily: (1) any physician of company; (4) the Moor my health or on the dimental illness. I also, to the extent allowe any person who shall linal. FRAUD WAR to injure, defraud or dinformation is quilty of the company of	edical Info health of so authoriz d by law, a have or cla RNING eceive an i	rmation Bui my family. I ze such dis Il provisions im any inter nsurer files	reau; or (5) any other specifically authorized closure of data to the sof law forbidding surest on any insurance an application or state	r organ the relate the reins the disclassible dissued the	ization, ease of surer of osure. I nereon.											
In compliant provide a living of a associate	ance with Popplicable arany persons	INVESTIGA ublic Law 91-508, and relevant material of to be covered. This r	ATIVE CONSUMER F investigative consume concerning character, report will be obtained company, a complete	REPORTS er report m general re I through p	NOTIFICAT lay be made putation, pe ersonal inte	(ION) e within the next few ersonal characteristic erviews with friends,	s and m neighbo	node of rs, and											
make a b companie company	orief report to es which oper for life or he	thereon to the Medic erates an information ealth insurance cover	be treated as confid al Information Bureau n exchange on behalf rage, or a claim for be e information in its file	u, a non-proof its mere enefits is s	rofit membe nbers. If yo	rship organization of apply to another B	f life ins ureau n	urance nember											
disclosed the Burea	only to you au and seek of the Burea	attending physician) a correction in accord	ange disclosure of any . If you question the ad dance with the proced s PO Box 105, Essex	ccuracy of ures set fo	information rth in the Fe	in the Bureau's file, y ederal Fair Credit Rep	ou may orting A	contact ct. The											
			lso release informatio o whom a claim form l	benefits ma			s to wh	om you											
ALL FE	TR	USTMARK ASSUME	IMPORTA NT OR EXAMINATIO ES NO RESPONSIBII	NS ARE T LITY FOR	PAYMENT	OF SUCH FEES.		ANT.											
	Please re	eturn this completed	d form to your Benef	its Admin	ISTRATOR AT 1	ne following Addre	ss:												
xSignatu	ure of Emplo	yee/Applicant				Date													
	·	censed Agent		Florida Li	cense ID #														
Signatu	re of Licens	sed Agent																	

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