

**TRUSTMARK LIFE INSURANCE COMPANY**

**PLEASE FOLLOW THE INSTRUCTIONS BELOW AND READ THE IMPORTANT NOTICE ON THE BOTTOM OF THIS FORM.**

- 1. Print out this form.
- 2. Fill out appropriate areas.
- 3. Put completed form, along with your medical bills and medical claims, in an envelope and mail to the address listed on the back of your medical I.D. card.

**1. COMPLETE FOR EACH SUBMISSION:**

A. Member Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Group Name(Employer) \_\_\_\_\_ Plan # \_\_\_\_\_

**B. Persons For Whom You Are Now Filing A Claim:**

FULL NAME	RELATIONSHIP TO MEMBER	BIRTHDATE
_____	_____	_____
_____	_____	_____

**2. IS THE CLAIM A RESULT OF AN ACCIDENTAL INJURY:**  Yes  No

If Yes:

How, when and where did the accident occur? \_\_\_\_\_

Did the injury occur in the course of employment?  Yes  No

**3. PLEASE COMPLETE THE FOLLOWING ANNUALLY OR ANYTIME THE INFORMATION CHANGES:**

A. Member Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Member Home Phone ( ) \_\_\_\_\_

B. Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

If your spouse is no longer employed, what date did he/she last work? \_\_\_\_\_

**C. List any members of your family covered by Medicare or other group insurance.**

Name(s) \_\_\_\_\_

Name of Other Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

**AUTHORIZATION** - I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY OR CONSUMER REPORTING AGENCY, OR EMPLOYER HAVING ANY RECORDS OR INFORMATION PERTAINING TO ALL MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, EVALUATION, DIAGNOSIS, TREATMENT OR PROGNOSIS, SPECIFICALLY TO INCLUDE PSYCHIATRIC, DRUG OR ALCOHOL ABUSE TREATMENT OF ME OR MY MINOR CHILDREN AND ANY OTHER NON-MEDICAL INFORMATION OF ME OR MINOR CHILDREN TO GIVE TO TRUSTMARK LIFE INSURANCE COMPANY, LAKE FOREST, ILLINOIS OR ITS LEGAL REPRESENTATIVES, ANY AND ALL SUCH INFORMATION. I FURTHER ACKNOWLEDGE THAT THE INFORMATION OBTAINED BY USE OF THIS AUTHORIZATION WILL BE USED BY TRUSTMARK LIFE INSURANCE COMPANY TO DETERMINE MY OR MY MINOR CHILDREN'S ELIGIBILITY FOR BENEFITS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION. I FURTHER AGREE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL, AND THAT SUCH AUTHORIZATION SHALL BE VALID FOR TWO YEARS FROM THE DATE SHOWN BELOW.

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

(ADULT PATIENT OR PARENT OF MINOR PATIENT)

**Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**