INSTRUCTIONS

Complete *Part I - Statement of the Insured*. The Insured must sign and date the authorization and complete *the Education and Training Evaluation*.

Part II - Statement of Employer must be completed by your employer confirming your last day worked.

Have the physician complete *Part III - Attending Physician's Statement and the Functional Capacity Evaluation*.

Trustmark Life Insurance Company of New York

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APPLICATION FOR WAIVER OF PREMIUM

PART I STATEMENT OF THE INSURED

Name _____ Date of Birth ____/____/____ Policy Number _____

Social Security # _____

Insured's Address _____ Telephone No. _____
(STREET) (CITY) (STATE) (AREA) (NUMBER)

Name and Address of Employer _____ Date Employed _____

Occupation _____ Principal Duties _____

Doctors Consulted:

_____
(NAME) (ADDRESS) (DATES)

_____
(NAME) (ADDRESS) (DATES)

_____
(NAME) (ADDRESS) (DATES)

Name of Hospital _____ Date Admitted _____ Date Discharged _____

Describe nature of illness or injury _____

1. If ILLNESS, on what date did you first notice the illness?

_____

2. If Accident, on what date? _____

Were you at work? ☐ YES ☐ NO

How did it happen?

3. Date you stopped working.

_____ Hour _____ ☐A.M. ☐P.M.

4. Dates you were continuously confined to your home.

From _____ To _____

5. Date you resumed working.

_____ Hour _____ ☐A.M. ☐P.M.

6. If unable to resume work at present, about what date should you be well enough to resume work? _____

7. Are you making claim with any other company? _____ (YES OR NO)

_____
(COMPANY NAME) (AMOUNT OF POLICY)

_____
(COMPANY NAME) (AMOUNT OF POLICY)

PART II STATEMENT OF THE EMPLOYER

This statement must be completed by the supervisor or timekeeper of the employer. If the insured is self-employed, the insured will complete the following statement giving all the details.

1. Occupation of the insured at the time of disability?

_____

2. Employed how many days per week? _____

3. Average monthly earnings? _____

4. Date employee last worked?

_____ Hour _____ ☐A.M. ☐P.M.

5. Date employee returned to work?

_____ Hour _____ ☐A.M. ☐P.M.

6. Occupation in which the insured returned?

_____

_____
(COMPANY NAME) (ADDRESS)

_____
(CITY) (STATE) (ZIP)

_____
(SIGNATURE) (OFFICIAL POSITION)

_____
(TELEPHONE) (DATE)

Trustmark Life Insurance Company of New York,
Albany, New York

PART III ATTENDING PHYSICIAN'S STATEMENT

Patient's Name _____ Age _____

HISTORY (a) When did present illness begin, or injury occur? (b) Date insured was obligated to cease work? (c) Is there a previous history of this illness?	
PRESENT CONDITION (a) Subjective symptoms (b) Objective findings *Give report of x-rays, E.K.G.s, or any other special tests.* (c) Is insured { Ambulatory?..... ☐ Bed confined?..... ☐ House confined?..... ☐ Hospital confined?..... ☐	
DIAGNOSIS	
TREATMENT (a) Date of first visit..... Date of last visit ..... Frequency of visits ..... (b) When did you last examine the insured?	
PROGRESS { Recovered..... ☐ Improved..... ☐ Unimproved..... ☐ Retrogressed..... ☐	
DEGREE OF DISABILITY	REGULAR WORK / OTHER WORK
(a) Has the insured been able to do any work; if so, from what date?	Mo___ Day___ Yr___ / Mo___ Day___ Yr___
(b) If not, when do you think he will be able to work? { Approximate date.....	Mo___ Day___ Yr___ / Mo___ Day___ Yr___
Indefinite..... ☐	
Never..... ☐	
(c) Would rehabilitation to some other occupation be feasible? Has rehabilitation been suggested? _____ What was patient's response? _____	

REMARKS

Physician _____
(PRINT NAME)

Address _____
(STREET NUMBER)

Phone _____ Date: _____

Signature of Physician _____ M.D.
(PLEASE ALSO SIGN AUTHORIZATION BELOW)

_____
(CITY) (STATE)

AUTHORIZATION: I hereby authorize the hospital to release information on this patient to the TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK or its representative.

Signature of Physician _____ M.D.

Trustmark Life Insurance Company of New York,
Albany, New York

DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Trustmark Life Insurance Company of New York and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Life Insurance Company of New York or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Life Insurance Company of New York. I AGREE the information obtained with this Authorization may be used by Trustmark Life Insurance Company of New York and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Life Insurance Company of New York and affiliates to report to ICS, any dates of past or present claims filed by me.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim or each such violation.

Date: _____ Signature: _____

Date of Birth_____/_____/_____ Relationship if other than insured:_____

Trustmark Life Insurance Company of New York,
Albany, New York