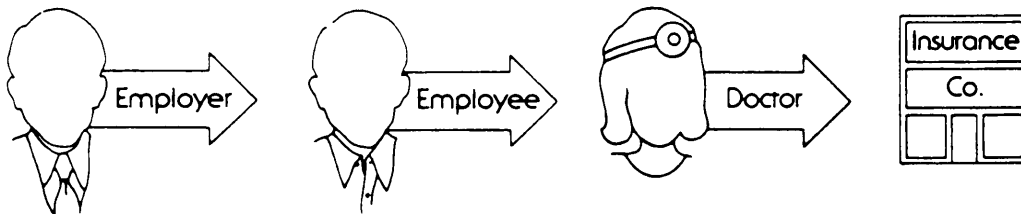


Group Long Term Disability **CLAIM**

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 60 to 90 days prior to the end of the elimination period:

- A. Complete the back of this form in full and transmit this portion only to address above.

Include:

- Job description (detailed duties)
- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed include copy of First Report of Accident and the decision

- B. Give remaining two-part form to claimant for completion

Request

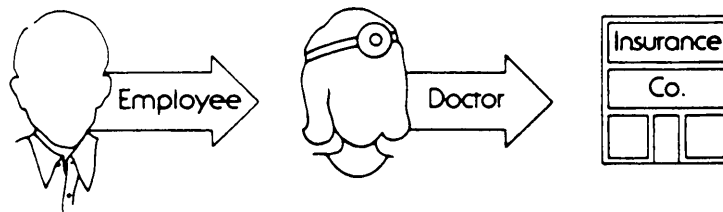
- Birth certificate (short duration claim and under age 50 not necessary at this time)
- Copy of awards from other source of benefits: Social Security, Workers' Comp., retirement, state disability, others

- C. If claimant has more than one treating physician, give claimant additional forms for completion.

- D. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

Group Long Term Disability **CLAIM**

APPLICATION



EMPLOYEE — *form completion information*

Application for Group LTD— Instructions

- A. Complete and sign the authorization on the reverse side of this page. If you have more than one provider, please complete an authorization for each provider. This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).
- B. Complete employee claim statement in full.
Attach:
 - A copy of your birth certificate if disability is indefinite
 - A copy of Social Security and other income entitlement awards (or forward when received)
- C. Give this authorization and attached claim application to the physician treating you (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.
- D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

Do Not Detach

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected health Information (PHI).

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I authorize: _____ Release to: **Trustmark Life Insurance Company**
Name of Health Care Provider/Plan/Other **P.O. Box 7948**
Street Address **Lake Forest, IL 60045-7948**
City, State, Zip Code

Specify Dates or date ranges: _____

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Health care provided to me; or
- Payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to **Trustmark Life Insurance Company** (herein as referred to "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments, tests as well as any information regarding drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, or any other public or private entity as may be lawfully required. The information provided to **Trustmark Life Insurance Company**, its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be valid as the original.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person (s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or insurance fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

Claimant Signature/Legal Representative

Date

GROUP LONG TERM DISABILITY CLAIM APPLICATION TO BE COMPLETED BY EMPLOYEE

CLAIMANT	1. Full Name (Last, First, Middle Init.)		2. Social Security No.		3. Phone Number	
	4. Address		City		State	
	4. Address		City		State	
	4. Address		City		State	
EMPLOYMENT	5. Date of birth		6. Height		7. Weight	
	5. Date of birth		6. Height		7. Weight	
	5. Date of birth		6. Height		7. Weight	
	5. Date of birth		6. Height		7. Weight	
8. Sex		9. Marital Status		10. Spouse's date of birth		
8. Sex		9. Marital Status		10. Spouse's date of birth		
8. Sex		9. Marital Status		10. Spouse's date of birth		
8. Sex		9. Marital Status		10. Spouse's date of birth		
11. Is spouse employed?		12. Number of children (Under age 19)		13. List names and dates of birth of unmarried children who have not finished high school.		
11. Is spouse employed?		12. Number of children (Under age 19)		13. List names and dates of birth of unmarried children who have not finished high school.		
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11. Is spouse employed?		12. Number of children (Under age 19)		13. List names and dates of birth of unmarried children who have not finished high school.		
CLAIM HISTORY	14. Employer's Name		15. Group Policy No.		16. Occupation (List the duties of your occupation at the time of disability)	
	14. Employer's Name		15. Group Policy No.		16. Occupation (List the duties of your occupation at the time of disability)	
	14. Employer's Name		15. Group Policy No.		16. Occupation (List the duties of your occupation at the time of disability)	
	14. Employer's Name		15. Group Policy No.		16. Occupation (List the duties of your occupation at the time of disability)	
17. Date of accident or date first noticed symptoms of illness:		18. I have been unable to work because of the disability since:		19. I returned to work on a part time basis on:		
17. Date of accident or date first noticed symptoms of illness:		18. I have been unable to work because of the disability since:		19. I returned to work on a part time basis on:		
17. Date of accident or date first noticed symptoms of illness:		18. I have been unable to work because of the disability since:		19. I returned to work on a part time basis on:		
17. Date of accident or date first noticed symptoms of illness:		18. I have been unable to work because of the disability since:		19. I returned to work on a part time basis on:		
20. I returned to work on a full time basis on:		21. Is your accident or illness related to your occupation?		22. If "yes," explain		
20. I returned to work on a full time basis on:		21. Is your accident or illness related to your occupation?		22. If "yes," explain		
20. I returned to work on a full time basis on:		21. Is your accident or illness related to your occupation?		22. If "yes," explain		
20. I returned to work on a full time basis on:		21. Is your accident or illness related to your occupation?		22. If "yes," explain		
23. Describe how and where accident occurred or describe the onset and nature of your illness.		24. Date you were first treated for your illness or injury.		25. Treated by:		
23. Describe how and where accident occurred or describe the onset and nature of your illness.		24. Date you were first treated for your illness or injury.		25. Treated by:		
23. Describe how and where accident occurred or describe the onset and nature of your illness.		24. Date you were first treated for your illness or injury.		25. Treated by:		
23. Describe how and where accident occurred or describe the onset and nature of your illness.		24. Date you were first treated for your illness or injury.		25. Treated by:		
26. Have you ever had the same or similar condition in the past?		27. Treated by:		28. Describe other income you are receiving:		
26. Have you ever had the same or similar condition in the past?		27. Treated by:		28. Describe other income you are receiving:		
26. Have you ever had the same or similar condition in the past?		27. Treated by:		28. Describe other income you are receiving:		
26. Have you ever had the same or similar condition in the past?		27. Treated by:		28. Describe other income you are receiving:		
29. Have you, or do you plan to apply for benefit described above?		30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes?		Signature		
29. Have you, or do you plan to apply for benefit described above?		30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes?		Signature		
29. Have you, or do you plan to apply for benefit described above?		30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes?		Signature		
29. Have you, or do you plan to apply for benefit described above?		30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes?		Signature		

Fraud Statement for Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Fraud Statement for Arizona Residents

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud Statement for California Residents

For your protection, California law requires the following to appear: 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.

Fraud Statement for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Agencies.

Fraud Statement for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for Kansas, Oregon, and Vermont Residents

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Fraud Statement for Kentucky Residents

A person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud Statement for Arkansas, Louisiana, Texas, and West Virginia Residents

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for Minnesota Residents

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Statement for District of Columbia, Maine, Tennessee and Virginia Residents

WARNING: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OR INSURANCE BENEFITS.

Fraud Statement for New Hampshire Residents

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided under RSA 638:20.

Fraud Statement for New Mexico and Pennsylvania Residents

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Fraud Statement for New Jersey Residents

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Fraud Warning for Delaware, Idaho, Indiana, Ohio, and Oklahoma
As Well as for the Residents of All States Not Specifically Listed**

WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

Fraud Warning for New York

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 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 and to exceed five thousand dollars and the stated value of the claim for each such violation.

The information that I have provided on this claim form are true and complete to the best of my knowledge and belief.

Signature of Employee

Date

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient		Date of Birth	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", state when and describe.
	(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		(e) Names and addresses of other treating physicians
DIAGNOSIS	(a) Diagnosis (Including complications)	(b) If pregnancy, est. date of delivery	(c) Subjective symptoms
	(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)		
TREATMENT	(a) Date of first visit	(b) Date of last visit	(c) Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)
	(d) Nature of treatment (Including surgery and medications prescribed, if any)		
PROGRESS	(a) Has patient? <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?		(b) Is patient? <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> Hospital Confined?
	(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give Name and Address of Hospital Confined from _____ through _____
CARDIAC	(a) Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)		(b) Blood Pressure (Last Visit) _____ / _____ Systolic/Diastolic
	(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles) <input type="checkbox"/> Class 1 – No limitation of functional capacity; capable of heavy work*. No restrictions. (0 – 10%) <input type="checkbox"/> Class 2 – Medium manual activity*. (15 – 30%) <input type="checkbox"/> Class 3 – Slight limitation of functional capacity; capable of light work*. (35 – 55%) <input type="checkbox"/> Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 – 70%) <input type="checkbox"/> Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 – 100%) Remarks: _____		
IMPAIRMENTS	(b) Mental Impairments (If Applicable) (a) Please define "stress" as it applies to this claimant. (b) What stress and problems in interpersonal relations has claimant had on job? <input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks: _____		
	(a) Is patient now totally disabled? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Date patient became disabled due to present illness
PROGNOSIS	(c) When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 Month <input type="checkbox"/> 1 – 3 Months <input type="checkbox"/> 3 – 6 Months <input type="checkbox"/> Never Applies To: <input type="checkbox"/> Patient's Job <input type="checkbox"/> Other Work		
	(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No
REHAB	(c) When could trial employment commence? Date: _____ PATIENT'S JOB <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Date: _____ ANY OTHER WORK <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		
	REMARKS Reason unable to work, in detail		
Name (Attending Physician) Print		Degree	Telephone
Street Address		City or Town	State or Province
Signature		Tax identification #	Zip Code
		Date	