TRUSTMARK INSURANCE COMPANY
400 Field Drive, Lake Forest, IL 60045

Application for: ☐ **Disability Coverage** ☐ **Increase to Existing Policy/Certificate #** ____

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

SECTION A. APPLICANT INFORMATION

Employer: Employee I.D. #. Annual Salary: $

Location: Department: Email Address

Social Security No. Date of Hire: Home Phone No.

Employee: Birth Date: Sex: ☐ M ☐ F Deduction Mode: ☐ 52 ☐ 26 ☐ 24 ☐ 20 ☐ 12 ☐ 11 ☐ 10 ☐ ____

Home Address: (Street) (City) (State) (Zip)

SECTION B. Disability Income Insurance. The employee is the only person eligible for Disability Income coverage.

1. Job Title: ____ Occupational Class: ____

   Are you actively at work? ☐Yes ☐No Hours scheduled per week: ____ Monthly Salary ____

2. a. Do you have any other Disability Income Insurance in force or applied for, excluding any employer paid plans?
   ☐Yes ☐No If yes, complete box below.

Name of Company	Monthly Amount	Benefit Period	Elimination Period

   b. Is this application to replace or cause change to any of the above? ☐Yes ☐No
   If yes, complete box below and submit any required replacement forms with this application.

Name of Company	Policy Number	Termination Date of existing coverage

3. **DISABILITY COVERAGE APPLIED FOR:** ☐Disability Insurance **Rider**: ☐Loss of Work

   Monthly Benefit: ____ Benefit Period: ____
   Elimination Period: ____ Modal Premium: ____

   The coverage applied for does not cover Disability that starts during the first 12 months from the coverage effective date if the Disability is due to a Preexisting condition. Preexisting Condition: Means a sickness or physical condition for which you were treated, received medical advice or had taken medicine within 12 months before the coverage effective date.

MODIFIED GUARANTEED ISSUE (Complete as required in addition to questions 1, 2, and 3)

4. a. In the past 90 days have You missed more than 5 days of work, other than for maternity leave or paid vacation?
   ☐Yes ☐No
   b. In the past 3 years have You been charged with driving under the influence of alcohol or any narcotic? ☐Yes ☐No
   c. In the past 12 months have You consulted a medical practitioner, received treatment, including medication or been hospitalized for any of the following:
   diabetes for which insulin has been prescribed ☐Yes ☐No
   back disorder ☐Yes ☐No
   knee disorder ☐Yes ☐No
   If yes to any of the above: Height ____ Weight ____

Remarks or Special Requests

I represent that all statements and answers given in this application are complete and true. I agree that all such statements and answers shall be made part of any insurance issued. [Coverage is provided under a policy issued to a trust.] **Acknowledgment** - I have received and read a copy of the Company's Notices about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices. **Trustmark Insurance Company is authorized to obtain an Investigative Consumer report on me. I understand that I may ask to be interviewed for this report. Authorization to Release Information** - I authorize the entities listed herein to give Trustmark Insurance Company, and through it, to its reinsurers and the Medical Information Bureau any data or records in the entities possession about me or my mental or physical health. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; the Medical Information Bureau; or any other organization, institution, or person that has data on me or my health. This authorization is valid for two years and six months from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person who signs this form may have a copy of it upon request.)

Signed at (city and state) ____ on (month/day/year) ____

X ____

Signature of Proposed Insured

Printed Name of Writing Agent Signature of Agent Agent I.D. Number

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