Trustmark
LIFE INSURANCE COMPANY
P.O. Box 7948
Lake Forest, Illinois 60045-7948
Phone (800) 307-3929 Fax (847) 615-5873

ACCELERATED LIFE BENEFIT REQUEST

I, _____ request payment of the Accelerated Life Benefit as
(Name of Employee)

provided under my group Life Insurance plan.

In New York we are required to tell you that: 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 not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee's Signature	Date
Absolute Assignee's Signature (if applicable)	Date

To The Administrator - Employer

We are anxious to process this claim as promptly as possible. You can help by being sure that the statements below are properly completed.

Administrator's or Employer's Statement

Name of Employer:			Contract Number:	
Name of Employee:	(First Name)	(Middle Initial)	(Last Name)	Date of Birth
Home Address:	(Street)	(City)	(State)	(Zip Code)
Social Security Number:	Job Title:	Annual Salary or Pension (if retired):		
Amount of Insurance	Date Employment Started:	Date Last Worked:		
Reason for Stopping Work:				

Date	Employer's Signature	Title

mail completed form to:
Trustmark Life Insurance Company
P.O. Box 7948
Lake Forest, IL 60045

Statement of Attending Physician

Name of Physician

Address (Street) (City) (State) (Zip Code)

Phone number TIN #

Diagnosis

Prognosis life expectancy

First date of treatment for above condition

Date Physician's Signature

Comments:

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: _____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Release to: **Trustmark Life Insurance Company**
P.O. Box 7948
Lake Forest, IL 60045-7948

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 healthy 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 as 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