TRUSTMARK LIFE INSURANCE COMPANY

400 FIELD DRIVE
LAKE FOREST, IL 60045

VERIFICATION OF DEPENDENT ELIGIBILITY
(for an Incapacitated Dependent)

MEMBER NAME: _____ **FOR:** _____

MEMBER SOCIAL SECURITY NUMBER: _____

NAME OF GROUP: _____ _____
Group Number

It is necessary at this time that we verify the eligibility of this dependent for coverage. Please answer the questions below and have this dependent 's attending physician complete the bottom portion of the form.

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TO BE COMPLETED BY THE MEMBER

DEPENDENT FULL NAME: _____

DEPENDENT BIRTHDATE: _____

IF OLD ENOUGH, IS THIS DEPENDENT MARRIED? _____YES _____NO

IS THIS DEPENDENT CAPABLE OF SELF-SUSTAINING EMPLOYMENT? _____YES _____NO

IF YES, DOES THIS DEPENDENT WORK FULL-TIME? _____YES _____NO

I CERTIFY THAT THE DEPENDENT HAS NOT EXERCISED ANY CONVERSION RIGHTS THAT MAY BE GRANTED UNDER THE PLAN, NOR HAVE ANY SUCH CONVERSION RIGHTS BEEN EXERCISED ON THE DEPENDENT'S BEHALF.

I AGREE THAT THE IMPOSITION OF ANY RIDERS OR LIMITATIONS PREVIOUSLY IMPOSED WILL CONTINUE TO BE APPLICABLE.

MEMBER'S SIGNATURE: _____ **DATE** _____

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TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

THE DATE THIS PHYSICAL OR MENTAL HANDICAP BEGAN:_____

IS THIS PATIENT CAPABLE OF SELF-SUSTAINING EMPLOYMENT? _____

DESCRIBE THE HANDICAP INVOLVED: _____

PLEASE ATTACH MEDICAL RECORDS FOR THE LAST 12 MONTH PERIOD.

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Approval of this verification form cannot be extended indefinitely. Additional information may be requested when a claim is submitted.

Thank you,

_____ _____ _____
(Date) (Department)