Trustmark Life Insurance Company of New York

Administrative Office
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PERMANENT WAIVER CLAIM FORM

PART I STATEMENT OF INSURED

Policy Number _____

Name _____ Telephone No. _____
(Area) (Number)

Address _____
Street City State Zip

Describe nature of sickness or injury: _____

On what date did you become totally disabled? _____

Are you continuously confined to your home? _____ (If yes, give dates) From _____ To _____

What is the date of your last visit to your doctor? _____

Have you considered rehabilitation for other forms of suitable, gainful employment or been in contact with either your state Division of Vocational Rehabilitation or a similar private Agency? _____ If "yes," please explain: _____

Are you able to perform any duties or work for profit or hire? _____

When do you expect to resume work? _____

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.

Resident of NY – 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:_____