

TRUSTMARK INSURANCE COMPANY
P.O. Box 7935 Lake Forest, Illinois 60045
800-918-8877

JOB LOSS REIMBURSEMENT REQUEST FORM

POLICYOWNER SECTION:

I hereby request to cancel the policy(ies)/certificate(s) listed below due to my loss of employment. Upon cancellation of this coverage, reinstatement is not available.

LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

POLICY/CERTIFICATE NUMBER(S): _____

DATE OF LAST DAY WORKED: _____

EMPLOYER NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

I agree that it is my responsibility to provide proof of my job loss to Trustmark Insurance Company. My signature hereby authorizes cancellation of my coverage as well as authorizes my employer to release proof of job loss to Trustmark Insurance Company. My signature also demonstrates that I have not submitted a claim, have no claim pending and relinquish all rights under the policy/certificate to file a claim once I have cancelled this coverage. Upon canceling this coverage retroactive to the effective date of coverage, all premiums submitted for this coverage will be refunded to the policyowner.

POLICYOWNER SIGNATURE: _____ DATE: _____