

Trustmark

LIFE INSURANCE COMPANY

VERIFICATION OF DEPENDENT ELIGIBILITY (For an Incapacitated Dependent)

Member's Name: _____ SS#: _____

Member's Address: _____

Name/Number of Group: _____

It is necessary at this time to verify the eligibility of this dependent for coverage. Please complete your section of the form, sign, and have the dependent's attending physician complete the bottom portion and attach the requested documents. Please submit the completed form with attachments to Trustmark Life Insurance Company, PO Box 7904, Lake Forest, IL 60045

TO BE COMPLETED BY THE MEMBER

Dependent's Full Name: _____

Dependent's Date of Birth: _____

I certify the above dependent is 19 years of age or older: _____ YES _____ NO

Unmarried: _____ YES _____ NO

Incapable of self-sustaining employment by reason of mental or physical handicap: _____ YES _____ NO

Is chiefly dependent on me for support and maintenance: _____ 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.

I certify that the above information is true to the best of my knowledge.

Member's Signature: _____ **Date:** _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

All questions must be completed in full prior to submitting to Trustmark.

The date this physical or mental handicap began: _____

Is this patient capable of self-sustaining employment? _____ YES _____ NO

Describe the handicap: _____

Please attach medical records for the last 12-month period.

I certify that the above information is true to the best of my knowledge. _____ YES _____ NO

Physician's Signature: _____ **Date:** _____

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

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www.trustmarklife.co