July 27, 2004

Trustmark Insurance Company Medical Questionnaire
PO Box 7930, Lake Forest, IL. 60045
Phone (800) 229-4543 Fax (847) 615-4954

Allergy/Allergic reaction Questionnaire

Proposed Insured:
Address:

Home Phone:
Work Phone:

Birthdate:
Employee:
Employer:
Cert.#:

1. Name, address and phone number of your doctor:____________________________________

   ____

2. Date last seen prior to application sign date:____
3. Current height and weight: ____
4. List all medications you are currently taking: _______________________________________

   ____

5. List all conditions for which you are currently seeing a doctor:_________________________

   ____

6. What is the exact diagnosis and cause of your condition? ____________________________

   ____

7. How frequent are your episodes? When was your last episode? ______________________

   ____

8. Do you have any complications? If yes, please give details: _________________________

   ____

9. Have you ever been hospitalized for this condition? If yes, please give details: __________

   ____

____________________________ ____________________________
Signature of Proposed Insured Date

DUE DATE: