

July 27, 2004

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

Back Questionnaire

Proposed Insured:

Birthdate:

Address:

Employee:

Home Phone:

Employer:

Work Phone:

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. How and when did your back injury occur and what was your diagnosis? _____

7. What type of treatment are you receiving for your back injury? _____

8. Are there any complications due to your back injury? _____

9. Is surgery being contemplated or have you been hospitalized? If so, please provide dates and duration: _____

10. Are you fully recovered? _____

Signature of Proposed Insured

Date

DUE DATE: