

**Trustmark Insurance Company Medical Questionnaire**  
**PO Box 7930, Lake Forest, IL. 60045**  
**Phone (800) 229-4543 x3413 Fax (847) 615-4954**  
**Cancer 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. Please give the date of first treatment and diagnosis: \_\_\_\_\_

7. Where is/was the malignancy located? And size of tumor? \_\_\_\_\_

8. Did you under go chemotherapy, radiation treatment or any other surgery? \_\_\_\_\_  
\_\_\_\_\_

9. Have you had other episodes or reoccurrence of cancer? If so, please list when &  
treatments received: \_\_\_\_\_

10. Please give your exact diagnosis (ex. basal cell, squamous cell) and what stage (ex. I, II,  
III)? \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date