

**Trustmark Insurance Company Medical Questionnaire**  
**PO Box 7930, Lake Forest, IL. 60045**  
**Phone (800) 229-4543 x3413 Fax (847) 615-4954**

**DOCTOR 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: \_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date