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

Hysterectomy Questionnaire

Proposed Insured:	Birthdate:
Address:	Employee:
	Employer:
Home Phone:	Cert.#:
Work Phone:	

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

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2. Date last seen prior to application sign date :__________________________________

3. Current height and weight: ____

4. List all medications you are currently taking: ____

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

____

6. What was the cause and/or complications that led to surgery?________________________

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7. What type of hysterectomy did/or will you have (Sub-total, total or radical)? Please provide the date of the surgery:____

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8. What was the diagnosis that led to the surgery?____________________________________

9. Was any cancer/malignancy found? If yes, what kind:________________________________

10. Is treatment on-going for this condition? Are you fully recovered?_____________________

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_________________________   _____________________
Signature of Proposed Insured   Date