July 27, 2004

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

STROKE QUESTIONNAIRE

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

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

____

2. Date last seen prior to app 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:____________________

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6. What was the cause of your stroke?____________________
7. Was surgery performed? If yes, give details on procedures and dates:____________________

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8. What type of follow up treatment is required, if any?____________________
9. Has there been any reoccurrence of stroke:____________________

____________________ ____________________
Signature of Proposed Insured Date

Due date: