TRUSTMARK INSURANCE COMPANY
ACKNOWLEDGEMENT AND AUTHORIZATION TO OBTAIN INFORMATION

I authorize the entities listed in this authorization to give Trustmark, and through it, to its reinsurers any data or records including pharmaceutical records that are individually identifiable in the entities possession about any proposed insureds or my mental or physical health. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; pharmacy; pharmacy benefit manager; MIB, Inc., formerly known as the Medical Information Bureau; or other organization, institution, or person which may have information about me or information pertinent to determine my eligibility for insurance as allowed or required by law. I also authorize Trustmark, or its reinsurers, to make a brief report of my protected health information to MIB. Information for consumers about MIB may be found at www.mib.com. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this authorization will be as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Trustmark. I understand that I may refuse to sign this authorization and still be assured treatment. Information disclosed under this authorization may be re-disclosed by recipient as permitted by law and may no longer be protected by HIPAA. (The person who signs this authorization may have a copy of it upon request.) If coverage cannot be issued as applied for, I authorize Trustmark to issue coverage on any insureds that are acceptable to Trustmark, to reduce benefits that are acceptable to Trustmark, and to adjust premiums to match the coverage issued. This authorization does not create any additional obligation by Trustmark to issue coverage to any proposed insured.

I acknowledge the application for life insurance on my life in the amount of $ «FaceAmount»

Name of Employee: _____

Name of Employer: _____

Employee Social Security Number: _____

Name of Spouse/Child (age 15 and over): «Insured»

Signature of Proposed Insured or Authorized Representative or Legal Guardian:

_____ _____
Signature of Spouse if to be Insured **Soc. Sec. No**

_____ _____
Signature of Co-owner or Child age 15 and over **Soc. Sec. No**

_____ _____
Signature of Employee **Soc. Sec. No**

_____ _____
Date Signed **Application Number**

Trustmark Voluntary Benefit Solutions
400 Field Drive, Lake Forest, Illinois 60045
(800) 918-8877

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