July 27, 2004

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

LUNG Disorder/Disease 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 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. What is the cause and exact diagnosis of your lung disorder/disease?_____

_____

7. Have you had or going to have surgery? When, Where and What was done?_____

_____

8. What kind of treatment are you receiving, if any?_____

9. Was any malignancy found?_____

10. Do you require follow up treatment? If yes, give details:_____

_____ _____
Signature of Proposed Insured Date

DUE DATE: