☒ **TRUSTMARK INSURANCE COMPANY**
☐ **TRUSTMARK LIFE INSURANCE COMPANY**
400 Field Drive, Lake Forest, IL 60045

Application for Life Insurance
☐ **Increase to Coverage** ☐ **Reinstatement of Coverage #** ____________

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

SECTION A. APPLICANT INFORMATION

Employer:	Employee I.D. #.	Annual Salary: $	☐ Full-Time ☐ Part-Time
Location:	Department:	Email Address	
Social Security No.	Date of Hire:	Home Phone No.	
Employee:	Birth Date: Sex: ☐ M ☐ F	Deduction Mode:	☐ 52 ☐ 26 ☐ 24 ☐ 20 ☐ 12 ☐ 11 ☐ 10 ☐ ______
Home Address: (Street)	(City)	(State)	(Zip)

SECTION B. LIFE INSURANCE

Complete Questions 1 through 8. Answers to these questions apply to both the Proposed Insureds and all Dependent Children for whom coverage is applied.

1. Proposed Insured	Birth Date	Age	Birth State	Height	Weight	Beneficiary/Relationship
1 ☐ E ☐ S ☐ C ☐ G ☐ M ☐ F						
1a. ☐ E ☐ S ☐ C ☐ G ☐ M ☐ F						

2. Prop. Insured	UL	Term	Increase to Coverage #	HDB	HH/LTC	EOB	BRR	BRR/EOB	LW	ADB	WP	G
1	☐	☐	________	☐	☐	☐	☐	☐	☐	☐	☐	☐
1a.	☐	☐	________	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. Prop. Insured	Amount of Insurance	Amount Purchased by premium payment of	UL Death Benefit Level	UL Death Benefit Inc.	EZ Value Weekly Increase - Duration		
1	$ ________	$ ______ / ______	☐ A	☐ B	☐ $1-5 yrs	☐ $1-10 yrs	☐ $2-5 yrs
1a.	$ ________	$ ______ / ______	☐ A	☐ B	☐ $1-5 yrs	☐ $1-10 yrs	☐ $2-5 yrs

4. ☐ **Children's Term Insurance Rider. (CT).** ☐ $5,000 ☐ $10,000. List all dependent children who are under age 24 and proposed for coverage. Children's Term Insurance Rider is part of the coverage on the life of: ☐ Proposed Insured #1 or ☐ Proposed Insured #1a. Use the Remarks Box or separate sheet of paper for additional dependents, if necessary.

Name	DOB	Relationship	Name	DOB	Relationship

Question	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 1a Yes	Proposed Insured 1a No	Dependent Children Yes	Dependent Children No
5. Will this insurance replace, in whole or in part, any life, accident and sickness, long-term care insurance or annuity? **If yes, provide name of company and amount of insurance under "Remarks or Special Requests."**	☐	☐	☐	☐	☐	☐
6. Does anyone proposed for coverage smoke cigarettes or during the past 12 months has anyone proposed for coverage smoked cigarettes?	☐	☐	☐	☐	N/A	N/A
7. Is any person to be insured now disabled, been seen by a physician or treated in a medical facility, including a doctor's office, within the last 6 months for illness or disease (other than flu and colds)?	☐	☐	☐	☐	☐	☐
8. Has any person to be insured been treated for, or diagnosed by a member of the medical profession as having, Acquired Immune Deficiency Syndrome (AIDS) or tested positive on an AIDS or HIV test?	☐	☐	☐	☐	☐	☐

If yes to either Question 7 or 8, or if Application is Simplified Issue, Complete Question 9.

9. Has any person to be insured:	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 1a Yes	Proposed Insured 1a No	Dependent Children Yes	Dependent Children No
a. Had, within the past 5 years: heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding any testing for HIV antibodies); liver disease; lung disease; or other known health impairments?	☐	☐	☐	☐	☐	☐
b. Within the past 10 years received medical treatment or counseling, or participated in a rehabilitation program, for alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
c. Seen a medical practitioner in the past 12 months for anything other than a routine physical examination?	☐	☐	☐	☐	☐	☐

10. If you answered "YES" to questions 7, 8, or 9 give details below:

Question	Person to whom it applies	Illness/Injury/Details	Date of last Visit	Doctor's Name/Address/Phone

Remarks or Special Requests

I represent that all statements and answers given in this application about me or my dependents are complete and true. I agree that all such statements and answers shall be made part of any insurance issued. Under penalties of perjury, I certify: (1) that the Social Security number shown above is correct; and (2) the IRS has not told me that I am subject to backup withholding. **I understand that: 1) the insurance will be effective on the date assigned by Trustmark; and 2) I must be actively at work at my employer named above on the first premium payroll deduction date, to be eligible for insurance.** I certify that I received no illustration in the sale of this life insurance Policy/Certificate. I understand that an illustration conforming to the Policy/Certificate as issued will be provided no later than at the time of Policy/Certificate delivery. Coverage may be provided under a policy issued to a trust.

Acknowledgment - I have received and read a copy of the Company's Notices about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices. **Trustmark is authorized to obtain an Investigative Consumer report on me. I understand that I may ask to be interviewed for this report.**

Authorization - I authorize the entities listed in this authorization to give Trustmark, and through it, to its reinsurers and the Medical Information Bureau any data or records in the entities possession about me or my mental or physical health. This authorization applies to data or records about my spouse and any child proposed for insurance in this application. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; the Medical Information Bureau; or other organization, institution, or person which may have information pertinent to determine my eligibility for insurance. 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. (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.

Agent's Statement: To the best of your knowledge, will this insurance replace any existing life, accident and sickness, long-term care insurance or annuity? ☐ Yes ☐ No (Proposed Insured #1)
☐ Yes ☐ No (Proposed Insured #1a)

I certify that no illustration was used in the sale of this life insurance Policy/Certificate.

Signed at (city and state)________________________________

____
Printed Name of Writing Agent

(month/day/year)____

X ____
Signature of Agent   Agent I.D. Number

X ____
Signature of Owner

Trustmark
INSURANCE COMPANY

Notice of Insurance Information Practices

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. As part of our normal procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry, if obtained, typically includes information as to your character, general reputation, personal characteristics and mode of living. You have a right of access and correction with respect to information collected about you. Address your request to receive additional information or a description of your rights to our Underwriting Department.

Information regarding your insurability will be treated as confidential. Trustmark Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Trustmark Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for insurance.

This Notification Must Be Delivered To Proposed Insured.