TRUSTMARK INSURANCE COMPANY
400 Field Drive, Lake Forest, IL 60045

Application for LIfe Insurance:
Reinstatement of coverage # _____ ☐ **Increase to Coverage** _____
☒ **Universal Life** ☐ **Universal LifeEvent** ☐ **Guaranteed Universal Life**

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: University Health System | Employee I.D. #: | Annual Salary: $ | ☐ Full-Time ☐ Part-Time

Location: Building: | Department: | Email Address: Personal

Social Security No.: | Date of Hire: | Home Phone No.: Personal

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
1 ☒ E ☐ S ☐ C ☐ G ☐ M ☐ F					
1a. ☐ E ☐ S ☐ C ☐ G ☐ M ☐ F					

2. Prop. Insured	UL	Increase to Coverage #	HH/ LTC	ADD'L TERM	LW	ADB	WP
1	☒ _____	☐	☒	☒	☒	☐	☒
1a.	☐ _____	☐	☒	☒	☒	☐	☒

3. Prop. Insured	Amount of Insurance	Amount Purchased by premium payment of	UL Death Benefit Level	Inc.	EZ Value Weekly Increase - Duration		
1	$_____	$_____ / 24	☒ A	☐ B	☒ $1-5 yrs	☐ $1-10 yrs	☐ $2-5 yrs
1a.	$_____	$_____ / 24	☒ A	☐ B	☒ $1-5 yrs	☐ $1-10 yrs	☐ $2-5 yrs

Beneficiary, if any

1 Name: First	M.I.	Last	Address	City	State	Zip

Phone	Social Security	Date of Birth	Relationship

1a Name: First	M.I.	Last	Address	City	State	Zip

Phone	Social Security	Date of Birth	Relationship

Contingent Beneficiary, if any

1 Name: First	M.I.	Last	Address	City	State	Zip

Phone	Social Security	Date of Birth	Relationship

1a Name: First	M.I.	Last	Address	City	State	Zip

Phone	Social Security	Date of Birth	Relationship

4. ☐ **Children's Term Insurance Rider. (CT)**. ☐ $5,000 ☐ $10,000. List all dependent children who are under age 25 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

	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?	☐	☐	☐	☐	☐	☐

	Proposed Insured 1		Proposed Insured 1a		Dependent Children	
	Yes	No	Yes	No	Yes	No
9a. 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?	☐	☐	☐	☐	☐	☐
9b. Within the past 10 years received medical treatment or counseling, or participated in a rehabilitation program, for alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
9c. Seen a medical practitioner in the past 12 months for anything other than a routine physical examination?	☐	☐	☐	☐	☐	☐

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

9. Has any person to be insured:
   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/ Date	Date of Last Visit	Doctor's Name/Address/Phone

Remarks or Special Requests

If this application has been completed by electronic or telephonic means, I acknowledge that I have not myself physically signed the application but instead I hereby authorize Trustmark or its Agent to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes on this application and I agree that such printing shall be treated as a valid signature for all purposes on this form. I acknowledge that Trustmark or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. The responses received on this application form will be attached and made a part of the Policy/Certificate.

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. 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 MIB, Inc. formerly known as Medical Information Bureau; and 3) the Notice of Information Practices. Information for consumers about MIB may be found at www.mib.com. **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 MIB, Inc. 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; pharmacy or pharmacy benefits manager; or other medically related facility; insurance company; MIB, Inc.; or other organization, institution, or person which may have information pertinent to determine my eligibility for insurance. I also authorize Trustmark, or it's reinsurers to make a brief report on my protected health information to MIB, Inc. Information disclosed under this authorization may be re-disclosed by recipient as permitted by law and may no longer be protected by HIPAA. 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.

San Antonio, Texas
Signed at (city and state)

Lisa B. Nava
Printed Name of Writing Agent

(month/day/year) _____

X _____
Signature of Agent

Agent I.D. Number

X _____
Signature of Owner