



# **Trustmark**

## **GROUP INSURANCE**

### **FRAUD WARNING**

Any person who knowingly completes this application with false, misleading or incomplete Information may be subject to civil and criminal penalties.

### **AUTHORIZATION TO RELEASE INFORMATION**

I authorize the entities listed in this authorization to give Trustmark, and through it, to its reinsurers and the Medical Information Bureau any financial or medical [MQ1] data or records in the entities possession about me or my mental or physical health. This authorization applies to financial or medical 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; or the Medical Information Bureau which may have financial or medical 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. (My authorized representative and I are entitled to receive a copy of this authorization.)