Administered by

Starmark®

400 Field Drive • Lake Forest, IL 60045-2581
www.starmarkinc.com

Fully insured by

Trustmark
LIFE INSURANCE COMPANY

Participating Employer Application and Agreement

Instructions for completing this application and agreement:
1. The company officer and the writing agent must sign and date this application and agreement.
2. Attach a current copy of the employer's last state quarterly wage and tax statement.
3. Attach a copy of the most recent billing statement(s) from your previous carriers.
4. Attach a copy of the proposal indicating the employer's plan section(s) with this application.
5. Include a company business check for one month's premium made payable to Starmark.

Employer Information

FULL LEGAL NAME OF COMPANY		EMPLOYER TAX ID NUMBER
STREET ADDRESS (No PO boxes)	PHONE NUMBER	FAX NUMBER
CITY/STATE/ZIP	COUNTY	DATE BUSINESS STARTED (mm/yyyy)
NATURE OF BUSINESS		SIC CODE
COMPANY DESCRIPTION ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other__________		
PLAN ADMINISTRATOR (Name and title)		E-MAIL ADDRESS

Are there any other physical locations (i.e., subsidiaries or affiliates) to be covered? ☐ Yes ☐ No
If "yes," complete the following section. If more space is needed, use a separate sheet, include all information that is required below, and attach it to this application. NOTE: The sheet must be signed and dated by a company officer.

FULL LEGAL NAME OF COMPANY		TAX ID NUMBER
STREET ADDRESS (No PO boxes)	PHONE NUMBER	FAX NUMBER
CITY/STATE/ZIP	COUNTY	DATE BUSINESS STARTED (mm/yyyy)
NATURE OF BUSINESS	COMMON OWNERSHIP? ☐ Yes ☐ No	SIC CODE
COMPANY DESCRIPTION ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other__________		

Coverage Information

IMPORTANT: Coverage is not effective without written notification from Trustmark Life Insurance Company (Trustmark) or Star Marketing and Administration, Inc. (Starmark). Any existing coverage should remain in force until such written notification is received.

Requested **effective date** of insurance (mm/dd/yyyy): ________________

If other than the first day of month, please explain why: ________________

Number of **full-time and part-time** employees: ________________

Number of **full-time** employees: ________________

Number of **employees eligible** for plan: ________________

Number of employees **covered under or in election period** of COBRA or state continuation: ________________

Number of employees in their **waiting period**: ________________

Carve Out? ☐ Yes ☐ No If "Yes", class to be covered: ________________

Employer Name: ______________________________

Coverage Information (continued)

NOTE: Any employees who are in their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Employee Enrollment Form.

☐ Eligible employees will be insured the first day of the month following _________ days of continuous employment (waiting period).
☐ Waive the waiting period for all employees during the initial enrollment.

YES	NO	
☐	☐	1. Are there any employees who are not actively at work on the date of this application?
☐	☐	2. Are there any employees who have been absent from work 2 consecutive weeks in the past 12 months?
☐	☐	3. At any time during the past 24 months has your company had medical coverage terminated or a renewal of medical coverage refused?
☐	☐	4. During the last 12 months, has there been an increase or decrease of 10% or more in the number of employees?
☐	☐	5. During the last 12 months, has your company's turnover rate for employees exceeded 30%?

If "yes" to questions 1 through 5, please explain: ______________________________

____

If a plan compatible with a Health Savings Account (HSA) is selected, the employer will contribute to the account:
_______________ per employee; _______________ per family

If the employer intends to provide funds through a Health Reimbursement Arrangement (HRA), the employer will fund:
_______________ per employee; _______________ per family

For the HRA, will the employer allow funds to rollover? ☐ Yes ☐ No

Participation

Participation Requirements: Eligible employees and dependents may be able to waive medical and/or dental coverage and not be counted for participation requirements if they have comparable group coverage through their spouse and a minimum of 50 percent of all eligible employees have enrolled. **Attach a copy of your last state quarterly wage and tax statement.**

For medical coverage and all additional benefits, a minimum of 75% participation is required.
For Employee Life or Employee Long Term Disability coverage (without medical), 100% participation is required.
For Employee Dental coverage (without medical), 75% participation is required.

Contribution

Employer Contribution Requirements: Employer must contribute towards the overall cost of the group health plan. The minimum employer contribution is 25% of the total cost for employees and dependents or 50% of the total cost for employees.

EMPLOYER CONTRIBUTION FOR EMPLOYEES:	EMPLOYER CONTRIBUTION FOR DEPENDENTS:
_______________ %	_______________ %

Prior Coverage

NAME OF PREVIOUS MEDICAL GROUP CARRIER	NAME OF PREVIOUS DENTAL GROUP CARRIER
PRIOR MEDICAL COVERAGE HAS BEEN IN EFFECT SINCE:	PRIOR DENTAL COVERAGE HAS BEEN IN EFFECT SINCE:

Why are you leaving your current group carrier? ______________________________

Premium renewal date with your current group carrier: ______________________________

Attach a copy of the most recent billing statement(s) from your previous carrier(s).

Employer Name: ________________________________

Billing

Employers with 10 or more eligible employees: Choose one billing methodology (assuming no change in demographic composition of the employer, both methods will result in the same premium). NOTE: Some states may require composite rating.

☐ Individual Billing – Each eligible employee is charged a rate that depends on the individual's demographic and family status.

☐ Composite Billing – Rating factors for all eligible employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

PREMIUM BILLING TYPE:

☐ Monthly Premium Statement ☐ Electronic Funds Transfer (EFT) *(Complete Authorization Form AD34)*

"Bill to" Address (if different than Street Address):
If a "bill to" address is chosen, the following items will be sent to the ***physical address:*** certificates and ID cards, renewal packets, late payment reminders, nonpayment termination letters and all other correspondence. Items sent to the ***billing address*** are billing statements, late payment reminders and nonpayment termination letters.

NAME	BILLING ADDRESS	CITY	COUNTY	STATE	ZIP

"BILL TO" ADDRESS:

☐ Bill Payment Office ☐ Accountant ☐ Other ________________________________

Automated Customer Environment (ACE)

The ACE system is Starmark's Automated Customer Environment – a complimentary, user-friendly system that is easily accessible through the Starmark website. ACE provides Starmark customers with immediate access to enrollment and billing information.

☐ Yes, I would like to sign up for ACE.

☐ No, I do not want to sign up for ACE.

ACE CONTACT (Name and title)	E-MAIL ADDRESS

SELECT THE DESIRED BILLING OPTION:

☐ **E-mail** the billing statement ☐ **Mail** the billing statement

Electronic Communications

Employer consents to accept an electronic file version of the Certificate(s) of Insurance provided by Trustmark, administered by Starmark, for electronic delivery to each covered employee. Employer further agrees that it is solely responsible for providing each covered employee electronic access to the most current version of any electronic file provided by Starmark to the employer. Upon request by a covered employee, a paper copy of the Certificate of Insurance may be obtained from Starmark.

Employer also consents to receive information regarding its coverage with Trustmark and services provided by Starmark, via e-mail. In addition, employer understands that Starmark has established a secure website through which authorized individuals can receive updated information about their coverage with Trustmark. Information on how to access the website will be given to all authorized individuals. Employer further understands that it can accept or decline to receive information through the website and receive all updated information in paper or non-electronic format. Employer also understands, that if it agrees to receive the information via the website, employer can at a later date withdraw its consent to receive information through the website.

☐ Accept ☐ Decline

Employer Name: ____

General Representations and Agreements

Eligible Employees: Employer certifies that it employs the number of full-time employees (30 hours or more per week; Ohio – 25 hours per week) as noted previously on this form and that no part-time employees are to be included for coverage. Employer agrees to make the benefit plans available to all present and future eligible employees, and understands that each employee must satisfy all eligibility requirements for insurance to become effective.

Effective Date: Employer understands that **no insurance will become effective without written notification by** Trustmark or its administrative representative, Starmark.

Medicare as Payor: Employer understands that medical benefits for employees or spouses who are age 65 and over will be paid secondary to Medicare when an employer has less than 20 employees. Covered charges will be reduced by any benefits payable by Medicare. When an employer has 20 or more employees, medical benefits will be paid primary to Medicare. An employee may choose to voluntarily waive coverage under the medical plan and elect Medicare as sole payor.

Termination: Employer understands that he may cancel his insurance at any time by giving 30 days advance written notice to Trustmark or to Starmark. Trustmark may cancel the employer's insurance only for stated reasons, such as inadequate participation or contribution; nonpayment of premium; or fraud.

Producer: Employer understands that the **producer** submitting this application represents the employer's interest, not that of Trustmark, and that the **producer has no right to bind coverage, to alter terms of the Group Insurance Contract or Application in any manner, or to adjust any claim for benefits under the Group Insurance Contract.**

Subscription to Trust: Employer hereby applies for participation in The Starmark MET Group Insurance Trust and for enrollment in the Group Insurance Contract established thereunder. The coverage(s) selected by Employer will be shown on a proposal.

Employer understands that: (a) as an employer, he is establishing this plan and that neither Starmark, the Policyholder Trustees, nor Trustmark are acting as "sponsor" or "plan administrator," as defined in the Employee Retirement Income Security Act of 1974 (ERISA) as amended; and (b) any compliance under ERISA that is applicable to the sponsor or plan administrator will be fulfilled by the employer, as its own legal counsel may determine. Employer understands that if it is subject to federal law which prohibits sex and age discrimination, it may have to choose pregnancy options or tailor its plans to comply, and/or seek legal counsel in this respect.

Employer agrees to be bound by the terms of the Group Insurance Contract and understands that any conflict will be resolved solely by reference to the Policy.

Employer agrees to promptly furnish Starmark, or Trustmark, with records or other information required to ensure proper administration of the insurance plans of The Starmark MET Group Insurance Trust and associated trusts.

Employer Name: ____

Plan Sponsor Certification

During the term of this group health benefit plan, the plan sponsor may receive Protected Health Information (PHI). As set forth in the HIPAA Privacy Rule (Rule), PHI includes individually identifiable health information and relates to the past, present or future:

- condition of an individual's physical or mental health;
- healthcare provided to an individual; or
- payment for healthcare provided to an individual.

The plan sponsor of a fully insured group health plan may choose not to receive PHI from us. If this selection is made below, the group health plan will be exempt from the administrative requirements of the HIPAA Privacy Rule. Whether or not the plan sponsor receives PHI from us, it must agree to safeguard and protect the confidentiality of any PHI you receive and to sign this Certification. The plan sponsor also agrees to amend the plan document of the group health plan consistent with this Certification.

EXEMPTION FROM ADMINISTRATIVE REQUIREMENTS

The group health plan may be exempt from the administrative requirements of the Rule if it does not create or receive PHI on plan participants, except for:

- summary health information (health information that does not identify the individual to whom it applies); or
- information on enrollment or disenrollment from the insurance health plan.

Administrative requirements include: assignment of privacy officer and contact person, employee training; safeguard protections for PHI; handling privacy complaints; sanctions for noncompliance with privacy policies and procedures; mitigation for harmful effects of use and disclosure in violation of privacy policies and procedures; developing privacy policies and procedures; creating Privacy Notice.

PLAN SPONSOR CERTIFICATION

The plan sponsor, or the designated representative of the plan sponsor, certifies that it will:

- Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the plan sponsor.
- Not use or disclose to anyone the PHI of any individual covered under this group health benefit plan other than as described in this Certification, and permitted or required by the HIPAA Privacy Rule and other applicable laws.
- Ensure that any agents, including subcontractors, to whom PHI is provided, agree to the same restrictions and conditions that apply to the plan sponsor in connection with the HIPAA Privacy Rule.
- Report to the group health benefit plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the HIPAA Privacy Rule and other applicable laws.
- Make available PHI as required in the Rule for Access of Individuals to their own PHI.
- Make available PHI as required in the Rule in order to amend PHI and incorporate any amendment to PHI in accordance with the Rule.
- Make available the information required to provide an accounting of disclosures of PHI as required by the Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health benefit plan available to the Secretary of the Department of Health and Human Services.
- Return or destroy, if feasible, all PHI received from the group health benefit plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Provide a List of Authorized Representatives, which includes the identity or job title, and affiliation of persons required or permitted to receive information in order to perform services on behalf of the group health benefit plan (e.g. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation vendor, claim auditor, provider network manager, utilization and review management vendor, stop loss insurance carrier, insurance broker/consultant), and any other entity subcontracted to assist in administrating the health plan.
- Provide PHI only to those individuals or entities identified on the List of Authorized Representatives.
- Provide an effective mechanism for resolving any issues of noncompliance with the provision of this Certification.

Please indicate your choice:

☐ **No**, the plan sponsor does not want to receive Protected Health Information and understands that it is exempt from the administrative requirements of the Rule.

☐ Yes, the plan sponsor wants to receive detailed Protected Health Information and it will comply with the administrative requirements of the Rule.

Employer Name: ____________________

List of Authorized Representatives

List any individual other than the plan administrator who will perform administrative functions for your group health plan and may have access to Protected Health Information (PHI) or summary health information. These individuals are authorized to discuss PHI that is the minimum necessary to administer the group health plan.

NAME AND/OR TITLE OF PERSON	COMPANY NAME

How does the authorized person use or disclose PHI in the performance of his/her job duties? ____________________

____

(If more space is needed, please use another sheet of paper.)

NOTE: If there are any changes, additions or deletions to be made, the plan sponsor is required to notify Starmark within 30 days of the change.

Signature

I hereby represent that all the information herein, relative to this application and agreement, is true and complete and that I have read and understand the form. I understand that Trustmark will rely on these statements and this information in approving this application and in determining if the enrolling employees may become insured.

COMPANY OFFICER (Please print.)	PRODUCER SIGNATURE
TITLE (Please print.)	MANAGING GENERAL AGENT
COMPANY OFFICER SIGNATURE	DATE SIGNED

Administered by Starmark®

Fully insured by Trustmark LIFE INSURANCE COMPANY

Commission Notice

Commissions will be paid according to the terms of the most recent MGA contract or commission schedule on file.

Producer Name (Please print): ______________________________

Social Security Number: ________ – ______ – ________

Complete this section only if commissions are payable to an agency. Commission paid to an agency can only be changed by obtaining a written release from the agency or a broker of record letter from the group.

Agency Name (Please print): ______________________________

Federal Tax ID Number: ________ – ________________

Complete this section only if commissions are payable to more than one producer or agency. NOTE: The total percentage of commissions listed below must be 100 percent.

PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION ____________ %
PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION ____________ %
PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION ____________ %

I hereby certify that I, and any other agent or producer who will receive commissions, do hold valid Life, Accident and Health Licenses issued by the state in which this document was executed. I have reviewed all enrollment and application materials and, to the best of my knowledge, all of the information is correct. I know nothing unfavorable about this employer or individual(s) applying for insurance. Furthermore, I certify that this employer is a bonafide business establishment and that participation and contribution requirements have been met. Eligibility provisions and pre-existing condition limitations have been fully explained to and understood by the employer identified in this document.

I understand that I represent the interest of the applicant for insurance, not Trustmark Life Insurance Company, and have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is accepted. I understand that I have no right to bind this coverage, to alter terms of the insurance contract or application in any manner or to adjust any claim for benefits under the insurance contract.

Name of employer applying for insurance (please print): ______________________________

Producer signature: ______________________________ Date signed: ______________

Office Use Only

Group No. ____________ **State** ________ **Eff Date** __________ **MGA** ____________ **No. of Lives** ______