

EMPLOYEE ENROLLMENT FORM
To be completed by the EMPLOYEE ONLY
Print legibly in ink only

Note: If you make a mistake when completing an answer, please correct, initial and date.

NOTICE: A 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.

New Hire Late Enrollment Reinstatement Special Enrollee (include completed Special Enrollee Form (AD41))

EMPLOYER INFORMATION

Group Name _____ Location _____ State _____ ZIP _____ Group No. _____
 Plan Choice, if available: Deductible _____ Physician/Hospital Network _____

EMPLOYEE INFORMATION - ALL FULL-TIME EMPLOYEES MUST COMPLETE THIS SECTION

| | | |
|--|------------------------|--|
| Name | M.I. | Last |
| Street | City | State ZIP |
| Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security Number | Birth Date |
| | | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married |

Work Phone () _____ Home Phone () _____ E-Mail _____

Date Employed Full Time _____ Job Title _____
mm/dd/yyyy

Hours Worked Per Week _____ Annual Salary \$ _____

If no longer employed, but on **COBRA or State Continuation**, enter employment termination date _____
mm/dd/yyyy

| | | | | |
|------------------|-------|------|------|--------------|
| Beneficiary Name | First | M.I. | Last | Relationship |
|------------------|-------|------|------|--------------|

LIST DEPENDENTS TO BE COVERED - If waiving dependents, must complete **WAIVER OF COVERAGE** section

| (First) | NAME | (Last) | BIRTH DATE | SEX | |
|---------|------|------------|------------|--------------------------|--------------------------|
| | | | | M | F |
| Spouse | | Occupation | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | | <input type="checkbox"/> | <input type="checkbox"/> |

Note: A dependent child is an unmarried child to age 25.

PROOF OF PRIOR COVERAGE

Complete this section only if you or your dependents are not covered under your employer's current group health plan. Did you or your dependent(s) have **MAJOR MEDICAL** coverage with another carrier(s) other than your current employer coverage within the past 12 months?
 Yes No

If yes, complete the following. (If insured with more than 1 carrier within the past 12 months, please attach certificate(s) of creditable coverage from prior plan(s)):

Employer Name _____ Phone () _____

Prior Carrier Name _____ Phone () _____

Policy No. _____ Effective Date _____ Termination Date _____

Covered Members (check all that apply) Employee Spouse Child(ren)

OFFICE USE ONLY

UND _____ EFF _____ SUB _____

MEDICAL INFORMATION

SECTION A: The following questions apply to **ALL** individuals for whom insurance coverage is requested.

1. Employee's Height _____ Weight _____ Spouse's (if applicable) Height _____ Weight _____
2. Have you or your spouse used any tobacco products in the past 12 months?
 Employee: Yes No Spouse: Yes No
3. **Within the last 4 years**, have you or any dependent been diagnosed with, received or been recommended to have treatment and/or medication(s) for, consulted a physician or other medical professional or had any test performed for any disorders or conditions of the following?
 Yes No
 If yes, please check all that apply.
 back stroke intestinal reproductive organs colon kidney muscular mental or emotional
 liver tumor/cancer diabetes respiratory systemic arthritis neurological seizures
 heart or circulatory (other than high blood pressure)
4. **Within the last 4 years**, have you or any dependent used drugs not prescribed by a physician, been advised to have treatment or been treated for drug abuse, alcoholism or been a member of Alcoholics Anonymous?
 Yes No
5. Have you or any dependent ever had positive ELISA, ELISA, Western Blot, blood tests indicating HIV antibodies or been treated and/or advised by a medical practitioner as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune system deficiency?
 Yes No
6. Have you or any dependent been hospitalized, had surgery, had more than \$5,000 in medical expenses in the last 12 months or been advised that hospitalization or surgery is necessary?
 Yes No
7. Are you or any dependent pregnant? Yes - Pregnancy due date _____ No

SECTION B: The following questions apply to **ALL** individuals for new groups with **LESS THAN 10** medical lives and to **ALL NEW ENROLLEES FOR INFORCE GROUPS**.

8. **Within the last 4 years**, have you or any dependent received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following?
 Yes No
 If yes, please check all that apply.
 ear eye hernia thyroid urinary tract allergy digestive system
 headache breast asthma rectal high blood pressure prostate ulcer
9. **Within the last 4 years**, have you or any dependent received treatment and/or medication(s) or been advised to receive treatment for any reason not already mentioned?
 Yes No

IMPORTANT! Please provide complete details to all medical questions that have been checked or answered "Yes". Include names, dates, diagnosis, and treatment and/or medication(s). Please indicate if complete recovery.

Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.

| Question Number | Person Treated | Nature of Condition; And/or Diagnosis | Duration Dates: From To | Explain Treatment: Include Date of Disability, Hospitalization, Medication (include dosage), Tests and Surgery | Results/Degree of Recovery |
|-----------------|----------------|---------------------------------------|-------------------------|--|----------------------------|
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NOTE: As part of our routine underwriting procedure, you may receive a phone call from the Home Office. The purpose of this call is to obtain information needed to evaluate and help speed the processing of your enrollment form. Your answers will be strictly confidential.

WAIVER OF COVERAGE

This is to certify that I have been given the opportunity to apply for group medical, dental and/or any other coverage offered by my employer and that I have decided not to apply. **I understand that if I choose to apply for this coverage in the future, I or my dependents may be considered late enrollees and coverage may be delayed for up to 18 months.**

I also understand that if my employer offers any ancillary benefits (Employee Life, Employee Short Term Disability or Employee Long Term Disability), I will be covered under these benefits unless I decline all coverage offered by my employer or am not otherwise eligible for that coverage.

Declining **all** group coverage offered by my employer at this time

Medical coverage declined for: Employee Spouse Child(ren)

Dental coverage, if available, declined for: Employee Spouse Child(ren)

Reason for declining coverage:

Covered by Spouse's Group Health Plan Government Plan

Individual Medical Plan Medicare

COBRA/State Continuation Medicaid

Not Affordable State Plan

Other (explain) _____

AGREEMENT AND AUTHORIZATION

Unless waived above, I request insurance under my employer's insurance plan as it is now or as it may be amended in the future. I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled. I represent that all statements and answers made in this application or any medical questionnaires are complete and true, and I understand that answers will be the basis of any coverage issued. I also understand that all statements and answers made in this application will be valid for 60 days from the date signed.

I authorize Trustmark, its authorized representative Star Marketing and Administration, Inc. (Starmark), its reinsurers and consumer reporting agencies, or any other authorized representatives, to obtain, use, and/or disclose certain information about me as indicated below.

Trustmark or Starmark may obtain and maintain Protected Health Information (PHI) about me to perform specific functions. This Authorization describes the type of information that is collected and my rights regarding how that information can be used.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- condition of my physical or mental health;
- health care provided to me; or
- payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

This information may be obtained from a number of sources including, but not limited to, applications for health plan coverage, questionnaires, health care providers, claims for payment filed by myself or health care providers, referrals made by health care providers, and my medical records. Other sources of PHI include group health plan administrators, insurance carriers, the Medical Information Bureau, employers, and other business partners such as pharmacy benefit managers, third-party administrators, consultants, agents or brokers. PHI may be obtained over the telephone, by mail, or e-mail.

PHI may be used by Trustmark or Starmark sales and underwriting personnel, legal, or others as may be necessary in order to provide insurance coverage. Additionally, PHI may be used by, and disclosed to other business partners, such as agents or brokers, for the purpose of determining eligibility for coverage.

Trustmark and Starmark are committed to the privacy of your PHI and have required all business associates and vendors to agree in writing to those same protections. Despite these efforts, we are required by law to advise you that your information may at some point fall outside of these protections.

I understand I have a right to inspect and copy my own PHI to be used or disclosed. I also understand that failure to sign this Authorization will result in my application not being considered. I agree this Authorization will be valid until Trustmark or Starmark has completed its determination of my eligibility for coverage. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

Employee Signature _____ **Date** _____

IMPORTANT NOTICE

PRE-EXISTING CONDITION LIMITATIONS and SPECIAL ENROLLMENT RIGHTS

Pre-existing Condition Limitation

This group health plan does not contain a pre-existing condition exclusion.

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after the involuntary loss of other coverage. In addition, if your current coverage changes or you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

Late Enrollees

Late enrollees will be required to satisfy an affiliation period of 90 days. If you request enrollment for yourself or eligible dependents after the original effective date of your employer's plan and following the initial enrollment period, coverage will start on the first day of the month following a 90 day affiliation period from the date the Employee Enrollment Form is signed. If the enrollment form is more than 60 days old, the enrollment form will be returned for updated information and signature and the effective date will be the first of the month following the date the enrollment form is received by Starmark after the 90 day affiliation period is satisfied.

THIS FORM MUST BE LEFT WITH ALL APPLICANTS

**TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY
(We, Us, Our)**

**NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

In order to provide insurance coverage and/or health plan administrative services, we must obtain and maintain Protected Health Information (PHI). This privacy notice describes the types of information that is collected and your rights regarding how that information can be used.

PHI is individually identifiable health information that is created or received by your provider, your health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present or future:

- condition of your physical or mental health,
- health care provided to you; or
- payment for the health care provided to you.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

Permitted/Required Uses and Disclosures of PHI

Your PHI will be used and disclosed for the purpose of routine treatment, payment and health care operations.

Use and Disclosure for Treatment

Your PHI may be used by, and disclosed to, health care providers including, but not limited to, doctors, nurses, laboratory technicians, medical students and other health care personnel involved in your treatment.

Use and Disclosure for Payment

Your PHI may be used by, and disclosed to, individuals involved in the collection of your premium and the payment of your benefits and other claims administration, including claim payment and adjudication or subrogation of health benefit claims. The use and disclosure also includes verification of participation or enrollment in the plan, eligibility for coverage and plan benefits. Your PHI may be shared with persons involved in utilization review, including pre-certification, pre-authorization, and concurrent and retrospective review, to assist in reimbursement of health care claims or other claims payment.

Use and Disclosure for Health Care Operations

Your PHI may be used and disclosed for plan operation purposes including, but not limited to: underwriting; premium rating, billing and premium adjustments; submitting claims; placing a contract for reinsurance of risk relating to claims for health care, including stop-loss and excess loss insurance; quality review assessments; audits, including fraud and abuse detection and compliance programs; business management and planning; the sale, transfer, merger or consolidation of a covered entity; legal or administrative services; actuarial pricing, studies and review; complaint review; and regulatory review and other legal compliance. In addition, your PHI may be used and disclosed for case management, and care coordination, contacting of health care providers and patients with information about treatment, drug and disease management alternatives and other related functions that do not include treatment.

We may share this information with our business associates for purposes of utilization reviews, appropriateness of care reviews, peer review for resolution of grievances, consultation with outside health care providers, consultants and attorneys, and other health related benefits and services that may be of interest to you. We require our business associates to sign an agreement specifying their compliance with our privacy policies.

We have developed privacy policies and procedures in order to ensure the privacy of your PHI. These policies and procedures are based on appropriate administrative, technical and physical safeguards necessary to maintain confidentiality. Access to your PHI is limited to those individuals that have a legitimate business need for that information. This protection extends to the use of your PHI by our business associates.

Other Permitted/Required Uses and Disclosures of PHI

We, or our approved business associates, may use and disclose your protected health information for reasons permitted by the Rule, including but not limited to the following:

- those required by law;
- in response to a court order or other legal proceeding;
- judicial and administrative proceedings;
- law enforcement purposes;
- to comply with worker's compensation or other similar laws;
- public health activities;
- health oversight activities;
- reporting abuse, neglect or domestic violence;
- the military if you are a member of the armed services;
- correctional institutions if you are an inmate;
- disclosures of decedent's information to coroners, medical examiners and funeral directors;
- organ, eye or tissue donation purposes;
- national security and intelligence agencies as authorized by law.

We will only use or disclose the minimum amount necessary to perform these functions. We may disclose PHI to the sponsor of your health plan for any purpose described in this section. If you are a member of a group health plan, contact your employer for the name of your plan sponsor.

Other Uses and Disclosures of PHI

Uses and disclosures of PHI for purposes other than those described in Permitted/Required Uses and Disclosures of PHI, will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information following the specific purpose contained in the authorization. You understand that we are unable to take back any disclosures already made with your authorization, and that we are required to retain any records we may have containing your PHI. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Your Individual Rights With Respect to PHI

Upon written request, you have the right to:

- request restrictions on certain uses and disclosures of your PHI. We are not required to agree to a requested restriction.
- receive confidential communication of PHI.
- access our records containing descriptions of your PHI.
- request an amendment to your PHI. We are not required to agree to a requested amendment.
- receive an accounting of impermissible PHI disclosures or disclosures made in compliance with the Rule for which an accounting is required.

Unless specifically requested otherwise, we will communicate PHI in connection with treatment, payment or health care operations, with any family member covered under your plan. Should any family member want a restriction on such disclosure of PHI, they must request such restriction in writing. Although we are not required to agree to a requested restriction, we will consider all factors explained in the request.

Except for uses and disclosures associated with treatment, payment, or health care operations, we do not use or disclose PHI when specifically protected by more stringent state law. Examples of more stringent state laws include those protecting HIV status, results of genetic testing, and indications of domestic abuse. We will follow state privacy laws that are more stringent than this federal law.

If you have chosen to receive this privacy notice electronically, you may also receive a paper copy from us upon your request.

Our Duties Regarding the Use and Disclosure of PHI

We are committed to maintaining your privacy and are required:

- by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI;
- to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this privacy notice, and have such change be effective for all PHI that is maintained. Notification of a revised privacy notice will be provided through one of the following:

- U.S. Postal Service;
- Revised Plan Document;
- Internet E-mail.

Up to date privacy notices are maintained on our Website.

How to File a Complaint Regarding the Use and Disclosure of PHI

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. All complaints must be in writing. Please be assured that you may not be retaliated against for filing a complaint.

How to Contact Us

You may contact our representative at the following:

Privacy Officer
HIPAA Compliance Department
Trustmark Insurance Company
P.O. Box 7961
Lake Forest, IL 60045-7961
Email – HIPAAComplianceDepartment@trustmarklife.com
Website – www.trustmarklife.com