

| | | |
|-----------------------------------|---------------|----------------|
| Group name: | | State: |
| Group contact: | Phone: | E-mail: |
| MGA or MBS representative: | | |
| Writing producer: | Phone: | E-mail: |

All licensing information must be current. Additionally, current and state-specific forms (if applicable) must be completed, signed and dated *prior* to the requested effective date. Visit www.starmarkinc.com for current forms. Note: Non-priority submissions must be received *before* the requested effective date.

A complete submission will expedite the underwriting process and ensure the desired effective date.

Priority Underwriting

Submissions for Priority Underwriting must include all items listed under the Submission Checklist below. Incomplete or missing information will render a group ineligible for Priority Underwriting and delay processing. Priority submissions may be received by Starmark up to five calendar days after the requested effective date.

Is this a Priority Underwriting submission? Yes No

Express Connect[®]

Submissions for enrollment through Express Connect must include all items listed under the Submission Checklist below, as well as:

- Census Form [S655-36]** – Indicates all employees eligible for coverage, including those waiving coverage and new hires who are eligible for coverage within 60 days. All employees, including those who are waiving coverage, must complete the enrollment process prior to the requested effective date of coverage.

Is this an Express Connect submission? Yes No

If yes, indicate the requested employee enrollment time frame: _____

Healthy Incentives

E-mail the proposal to Starmark at slproposals@starmarkinc.com and include the following:

- Federal Patriot Act Compliance Questionnaire and IRS W-9** – *Must be completed by the employer to ensure timely claims processing. Be sure to include any of the required forms based on the type of business (i.e., Individual/Sole Proprietor, Corporation, Partnership, etc.).*

Submission Checklist

- Employer application** completed, signed and dated by both the company officer and the writing agent
- Employee enrollment forms** for all eligible employees, including those waiving coverage and new hires who are eligible within 60 days. (*Note: Employee enrollment forms are **not** required with Express Connect submissions.*)
- Commission Notice** with the producer / agency's correct Social Security number / federal tax ID number
- Most recent quarterly wage and tax statement** listing all employees and their wages
- Submitted proposal** quoting the employees' coverage and plan design, and listing employee names
- Current carrier billing statement**, only if a takeover group
- Copy of the prescreen**, if available
- First month's premium check** – Choose one of these two options below:
 - Send the check with the submission and it will be held until offer acceptance.
 - Send the check at the time of offer. (*Note: This will delay the receipt of employee plan documents.*)

If a submission is missing any of these items, Starmark will send a fax or e-mail a list of outstanding items to you. Upon receipt of the outstanding information, Starmark will date stamp the item(s) and the file will be reviewed by the underwriter with other cases received on that date. If the outstanding items are not received within 72 hours, the group will be returned.

Fully insured plans are administered by Starmark and insured by Trustmark Life Insurance Company. Self-funded plans are administered by Starmark, and stop-loss insurance is provided by Trustmark Life Insurance Company. Plan availability and/or coverage may vary by state.

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 <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other _____ | | |
| PLAN ADMINISTRATOR (Name and title) | | E-MAIL ADDRESS |
| Are there any other physical locations (i.e., subsidiaries or affiliates) to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | SIC CODE |
| COMPANY DESCRIPTION <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 administering 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 |

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** _____



Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY

Policy/Group No. _____

Section No. _____

Effective Date _____

New Hire Waiting Period _____

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:

(To be completed by employer)

Insurer: _____ Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____ Insurer: _____

TO BE COMPLETED BY EMPLOYER

Employer Name: _____

Phone #: _____

Address: _____

Reason for Enrollment (Mark all that apply)

New Enrollment: ! New Group ! Open Enrollment ! New Hire (Date: _____) ! Late Enrollee

Special Enrollment: ! Adoption ! Court Order ! Dependent Addition ! Divorce ! Domestic Partner
! Loss of Coverage ! Marriage ! Newborn ! Other Date of Event: _____/_____/_____

Employment Status: ! Active ! Retiree (Retirement Date: _____/_____/_____)

! Illinois Continuation ! COBRA

! Employee ! Dependent

Qualifying Event: _____

Start Date _____/_____/_____ Projected End Date _____/_____/_____

A Employee Information

Name (Last) _____

(First) _____

(MI) _____

Job Title: _____

Hire Date: _____

Hrs/Week: _____

Marital Status: ! Married ! Single ! Divorced ! Widowed ! Domestic Partner

Home Address: _____

Apt #: _____

City: _____

State: _____

Zip: _____

Home (or Cell) Phone: (_____) _____

Business Phone: (_____) _____

Email Address (optional): _____

B Coverage Requested

Medical

Employee: ! Yes ! No

Spouse/Domestic Partner: ! Yes ! No

Child(ren): ! Yes ! No

Plan Choice: _____

Plan Choice: _____

Plan Choice: _____

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.



Employer Name _____ Employee Name _____

C Waiver of Coverage

Please complete this section only if **you are waiving (declining) coverage** for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- ! If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- ! If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- ! If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I **DO NOT** want, and hereby waive, coverage for (**initial** next to all that apply):

| | | | | | | |
|--|-----|--------|-----|----------------------------|-----|-------------------------|
| Medical for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Dental¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Vision¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Basic Life¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Dependent Life¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Voluntary Life¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Short-Term Disability¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |
| Long-Term Disability¹ for | [] | Myself | [] | My Spouse/Domestic Partner | [] | My Dependent Child(ren) |

¹ If offered.

I am **declining** group coverage for the following reason(s): (**check** all that apply)

- ! Spouse/Domestic Partner's Employer Plan
- ! Individual Coverage (Non-Group Plan)
- ! COBRA/State Continuation
- ! Medicare or other Government Program
- ! Other (please explain): _____

" If you are declining ALL coverage for ALL persons, please skip to the Acknowledgement & Signature section on page 10 of this application.



Employer Name _____ Employee Name _____

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- ◆ Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- ◆ Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an “eligible military veteran” is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____ Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ! Male ! Female

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____ Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ! Male ! Female

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____ Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ! Male ! Female

Eligible Military Veteran: ! Yes ! No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____ Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ! Male ! Female

Eligible Military Veteran: ! Yes ! No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____ Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ! Male ! Female

Eligible Military Veteran: ! Yes ! No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____



Employer Name _____ Employee Name _____

| | |
|---|-----------------------------------|
| Dependent Name (Last) _____ (First) _____ (MI) _____ | |
| Social Security Number: _____ | Date of Birth: / / |
| Weight: lbs. | Height: ft. in. |
| Gender: ! Male ! Female | |
| Eligible Military Veteran: ! Yes ! No | |
| HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____ | |

E Current/Prior Coverage Information

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within **24 months** prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the **past 24 months**, please indicate **NONE**. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. You will be subject to an automatic PEC Waiting Period of up to 12 months until the insurer receives evidence of prior coverage.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

| | |
|---|--|
| Employee Name (Last) _____ (First) _____ (MI) _____ | |
| ▶ Current/Most Recent Coverage: ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |
| ▶ Will the individual continue this coverage? ! Yes ! No | |
| ▶ Prior Coverage (if any): ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |
| Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____ | |
| ▶ Current/Most Recent Coverage: ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |
| ▶ Will the individual continue this coverage? ! Yes ! No | |
| ▶ Prior Coverage (if any): ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |
| Dependent Name (Last) _____ (First) _____ (MI) _____ | |
| ▶ Current/Most Recent Coverage: ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |
| ▶ Will the individual continue this coverage? ! Yes ! No | |
| ▶ Prior Coverage (if any): ! Group Medical ! Dental ! Individual Medical ! None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____ | |



Employer Name _____ Employee Name _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? ! Yes ! No

▶ **Prior Coverage (if any):** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? ! Yes ! No

▶ **Prior Coverage (if any):** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? ! Yes ! No

▶ **Prior Coverage (if any):** ! Group Medical ! Dental ! Individual Medical ! None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) _____ (First) _____ (MI) _____

| | |
|--|--|
| Medicare ! Part A ! Part B ! Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: ! Age ! Disability ! ERSD ! Dual Enrollment | Medicare Number (please include alpha prefix): |
|--|--|

Enrolling Individual Name (Last) _____ (First) _____ (MI) _____

| | |
|--|--|
| Medicare ! Part A ! Part B ! Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: ! Age ! Disability ! ERSD ! Dual Enrollment | Medicare Number (please include alpha prefix): |
|--|--|



Employer Name _____ Employee Name _____

F Health Statement

Instructions:

1. The information you provide in this application is confidential. You should discuss with your employer if you prefer to submit the completed health statement directly to the insurance company or insurance broker.
2. The health information you provide below will be used by the insurance company to determine the price to charge your group for the coverage applied for and whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage. Coverage for pre-existing conditions cannot be limited or excluded for dependents under the age of 19.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section G below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. After you submit this application, the insurance company may call you to obtain additional confidential information needed to evaluate and aid the processing of your application.

1 For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

| | | |
|---|-------|------|
| A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels? | ! Yes | ! No |
| B. Cancer or cancerous tumor? | ! Yes | ! No |
| C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system? | ! Yes | ! No |
| D. Diabetes? If yes, check all that apply: <input type="checkbox"/> Non-Insulin Dependent <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Insulin Pump | ! Yes | ! No |
| E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines? | ! Yes | ! No |
| F. Growth disorder or a disorder of the pancreas? | ! Yes | ! No |
| G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder? | ! Yes | ! No |
| H. Reproductive organ disorders or infertility? | ! Yes | ! No |
| I. Arthritis, or any other disorder of the joints, muscles, back, or bones? | ! Yes | ! No |
| J. Mental or emotional disorder? | ! Yes | ! No |
| K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system? | ! Yes | ! No |



Employer Name _____ Employee Name _____

| | | |
|--|-------------------------|----------------------|
| L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system? | ! Yes | ! No |
| M. Alcohol, drug, or substance use or dependency? | ! Yes | ! No |
| N. Organ or bone marrow transplant? | ! Yes | ! No |
| 2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant? Due Date: ____/____/____ (MM/DD/YYYY) If yes, are multiples (twins, triplets, etc.) expected? Are there any known complications, or is a cesarean section planned? | ! Yes ! Yes ! Yes | ! No ! No ! No |
| 3 Within the past 12 months, have you or your spouse/domestic partner used any tobacco products? Employee: Spouse/Domestic Partner: | ! Yes ! Yes | ! No ! No |
| 4 Within the past 12 months, has any applicant been prescribed medication (other than for the common cold or flu) that is not indicated elsewhere in this application ? | ! Yes | ! No |
| 5 Within the past 5 years, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for any illness, injury or health condition not indicated above ? | ! Yes | ! No |

G Additional Information

If you answered "Yes" to any of the questions above, you must complete this section.
If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? ! Yes ! No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

Currently taking medication? ! Yes ! No

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? ! Yes ! No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

Currently taking medication? ! Yes ! No



Employer Name _____ Employee Name _____

| | |
|--|---------------------------------|
| Question Number: _____ Name of Individual: _____ | |
| Condition/Diagnosis: _____ | Date Diagnosed (MM/YYYY): _____ |
| Treatment Received: _____ | |
| _____ | |
| Treatment ongoing? ! Yes ! No | Last Treatment Date: _____ |
| Surgery, additional tests or treatment recommended? _____ | |
| Medication Prescribed (if any): _____ | |
| _____ Currently taking medication? ! Yes ! No | |
| Question Number: _____ Name of Individual: _____ | |
| Condition/Diagnosis: _____ | Date Diagnosed (MM/YYYY): _____ |
| Treatment Received: _____ | |
| _____ | |
| Treatment ongoing? ! Yes ! No | Last Treatment Date: _____ |
| Surgery, additional tests or treatment recommended? _____ | |
| Medication Prescribed (if any): _____ | |
| _____ Currently taking medication? ! Yes ! No | |
| Question Number: _____ Name of Individual: _____ | |
| Condition/Diagnosis: _____ | Date Diagnosed (MM/YYYY): _____ |
| Treatment Received: _____ | |
| _____ | |
| Treatment ongoing? ! Yes ! No | Last Treatment Date: _____ |
| Surgery, additional tests or treatment recommended? _____ | |
| Medication Prescribed (if any): _____ | |
| _____ Currently taking medication? ! Yes ! No | |
| Question Number: _____ Name of Individual: _____ | |
| Condition/Diagnosis: _____ | Date Diagnosed (MM/YYYY): _____ |
| Treatment Received: _____ | |
| _____ | |
| Treatment ongoing? ! Yes ! No | Last Treatment Date: _____ |
| Surgery, additional tests or treatment recommended? _____ | |
| Medication Prescribed (if any): _____ | |
| _____ Currently taking medication? ! Yes ! No | |



Employer Name _____ Employee Name _____

H Additional Coverage Options

You should complete this section only if your employer offers any of the additional coverage options below.

Employee▶! **Dental:** ! PPO ! HMO

Dental HMO Office ID # (if applicable): _____

! **Vision** ! **Basic Life** ! **Dependent Life** ! **Voluntary Life:** Amount (if applicable): \$ _____! **Short-Term Disability** ! **Long-Term Disability**▶! **Employee Class** (employer will provide you with this information if needed): _____▶! **Salary** (if requesting life or disability coverage): \$ _____

! Hourly ! Weekly ! Monthly ! Semi-monthly ! Annually

Spouse/Domestic Partner▶! **Dental:** ! PPO ! HMO

Dental HMO Office ID # (if applicable): _____

! **Vision** ! **Basic Life** ! **Dependent Life** ! **Voluntary Life:** Amount (if applicable): \$ _____! **Short-Term Disability** ! **Long-Term Disability****Child(ren)**▶! **Dental:** ! PPO ! HMO

Dental HMO Office ID # (if applicable): _____

! **Vision** ! **Basic Life** ! **Dependent Life** ! **Voluntary Life:** Amount (if applicable): \$ _____! **Short-Term Disability** ! **Long-Term Disability****Beneficiary Information** (if requesting life insurance)

Primary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____

Secondary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____



Employer Name _____ Employee Name _____

I Acknowledgement & Signature

I understand, agree, and represent that:

- ! I have read this document or it has been read to me.
- ! The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- ! Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- ! I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- ! If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier 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 of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature _____ **Date** _____

" For assistance in completing this application, please contact your employer or insurance agent.
For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

IMPORTANT NOTICE

PRE-EXISTING CONDITION LIMITATIONS and SPECIAL ENROLLMENT RIGHTS

Pre-existing Condition Limitation

This group health plan contains a pre-existing condition exclusion for persons ages 19 and older that is limited to a maximum of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy including a short term plan, Medicare, Medicaid, CHAMPUS, Federal Employees Health Benefit Plan (FEHBP), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, governmental plans, church plan or a health plan issued under the Peace Corps Act, Social Security, or State Children's Health Insurance Program. You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, we will assist you in obtaining a certificate from any of these entities. This Pre-existing Condition Limitation notice is being issued to you pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and reflects the protections afforded under federal law. If the state law applicable to your plan is more beneficial to covered individuals as to the length of the pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your plan.

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 coverage was terminated as a result of loss of eligibility for the coverage or termination of employer contribution (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program 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

If you waive coverage at the original effective date of your employer's plan and do not qualify as a special enrollee, coverage will start as follows:

- If your employer's plan has been in force for less than 12 months, coverage will start on the plan's first anniversary.
- If your employer's plan has been in force for 12 months or more, coverage will start on the first day of the month following the date the Employee Enrollment Form is signed.

If you are hired after the original effective date of your employer's plan and request enrollment for yourself or eligible dependents following the initial enrollment period, coverage will start on the first day of the month following the date the Employee Enrollment Form is signed.

An enrollment form that is more than 60 days old will be returned for updated information and signature, and the effective date will be the first of the month following the date the original enrollment form was received by Starmark or the group's first anniversary, whichever is later. The pre-existing condition limitation above applies.

For more information, refer to your Certificate of Insurance or plan sponsor/employer.

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

NOTICE OF PRIVACY PRACTICES
Effective date of this notice: April 1, 2006

Our Commitment to Protecting Your Privacy

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.

As you may be aware, recent laws require that we provide you with notice as to how we protect an insured's "Nonpublic Personal Information." We want you to know that we are guided by our respect for the confidentiality of your Personal Information. We are providing you with this notice in accordance with recent laws and because we want you to know that we value your privacy.

You do not need to respond to this notice in any way.

Information We Collect

Personal Information is any information that we obtained about you in the course of issuing insurance, or providing you with any of our services. The information we obtain could include but is not limited to:

- Social Security number;
- Medical history;
- Employment history;
- Credit history;
- Income information; or
- Bank or credit card numbers.

This information may have been obtained from several sources including:

- Applications or other forms you complete;
- Your business dealings with us and other companies; or
- Consumer reporting agencies.

Our Privacy and Security Procedures

We protect your Personal Information. The only employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our insureds.
- We have guidelines in place to make sure that our business associates use information only for the purpose provided. Each business associate signs a contract agreeing to follow our privacy procedures.

Information We Disclose

We do not disclose any information about you to anyone, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for plan business purposes.

- Underwriting;
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;

- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.
- It may be shared to assess eligibility for insurance benefits or payment.
- It may be shared to find or prevent criminal activity, fraud, material misrepresentation or material non-disclosures in connection with an insurance issue.
- It may be shared with a medical care institution or professional to verify coverage.
- It may be shared with a medical care institution or professional relating to a medical problem of which the insured may not be aware.
- It may be shared with a medical care institution or professional to conduct an audit of their activities.
- It may be shared for case management activities.
- It may be shared to coordinate care.
- We may share information about drug and disease management approaches and treatment, and related information that is not treatment.
- It may be shared for the collection of premium, the payment of benefits and other claims administration.
- It may be shared with a regulatory authority.
- It may be shared with a law enforcement authority or other government authority as required by law.
- It may be shared as otherwise permitted or required by law.
- It may be shared in response to an administrative or judicial order, including a search warrant or subpoena.
- It may be shared to conduct actuarial or research studies. In this case individuals would not be identified in the research report. Material identifying an individual would be destroyed as soon as it was no longer needed.
- It may be shared with our business associates for use in auditing services or operations, or auditing marketing services.
- It may be shared with a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.
- It may be shared to consult with outside health care providers, consultants and attorneys, and other health related services.

We require those with whom we share information to agree to follow our privacy guidelines. In sharing information, we share only that which is reasonably necessary to accomplish the task. Please note that information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes.

Uses and disclosures of Personal Information for purposes other than those described above will be made only with your written authorization. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for 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 Personal Information. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Our Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding the information now and in the future. We are committed to maintaining your privacy and are required by law:

- to maintain the privacy of Personal Information and to provide you with notice of our legal duties and privacy practices with respect to Personal Information
- 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 Personal Information 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.

Upon written request, you have the right to:

- request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction
- receive confidential communication of Personal Information
- access our records containing descriptions of your Personal Information
- request an amendment to your Personal Information, although we are not required to agree to a requested amendment
- receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with the Rule (or state regulations, if applicable) for which an accounting is required.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department 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 address:

Privacy Officer

Privacy Request

Trustmark Companies

PO Box 7961

Lake Forest, IL 60045-7961

Email – PrivacyComplianceDepartment@Trustmarkinsurance.com

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by Us.