



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)

! 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):
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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):
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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.