

<b>Group name:</b>		<b>State:</b>
<b>Group contact:</b>	<b>Phone:</b>	<b>E-mail:</b>
<b>MGA or MBS representative:</b>		
<b>Writing producer:</b>	<b>Phone:</b>	<b>E-mail:</b>

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](http://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<sup>®</sup>

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](mailto: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
<b>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.</b>
Requested <b>effective date</b> of insurance (mm/dd/yyyy): _____ If other than the first day of month, please explain why: _____ Number of <b>full-time and part-time</b> employees: _____ Number of <b>full-time</b> employees: _____ Number of <b>employees eligible</b> for plan: _____ Number of employees <b>covered under or in election period</b> of COBRA or state continuation: _____ Number of employees in their <b>waiting period</b> : _____ 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.

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### 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.

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### 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
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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** \_\_\_\_\_

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

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

**NOTICE: A person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.**

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

**EMPLOYER INFORMATION**

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

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

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

Work Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Date Employed Full Time \_\_\_\_\_ Job Title \_\_\_\_\_  
 Hours Worked Per Week \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_  
 If no longer employed, but on **COBRA or State Continuation**, enter employment termination date \_\_\_\_\_  
mm/dd/yyyy

<b>Beneficiary Name</b>	First	M.I.	Last	Relationship
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**LIST DEPENDENTS TO BE COVERED** - If waiving dependents, must complete **WAIVER OF COVERAGE** section

**\*NOTE: Federal law (Medicare, Medicaid, and SCHIP Extension Act of 2007) requires Social Security numbers for all covered employees and their covered dependents.**

(First)	LEGAL NAME (Last)	BIRTH DATE	SOCIAL SECURITY NUMBER*	SEX
				M    F
Spouse	Occupation	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>

**Note:**  
 A dependent child is an unmarried child to age 26, or to age 30 for military veterans.

**PROOF OF PRIOR COVERAGE**

**Complete this section only if you or your dependents are not covered under your employer's current group health plan.** Did you or your dependent(s) have **MAJOR MEDICAL** coverage with another carrier(s) other than your current employer coverage within the past 12 months?

Yes  No

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

Employer Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Prior Carrier Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Policy No. \_\_\_\_\_ Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_

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

**OFFICE USE ONLY**

UND \_\_\_\_\_ EFF \_\_\_\_\_ SUB \_\_\_\_\_

**MEDICAL INFORMATION**

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

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

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

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

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

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

Question Number	Person Treated	Nature of Condition; And/or Diagnosis	Duration Dates: From To	Explain Treatment: Include Date of Disability, Hospitalization, Medication (include dosage), Tests and Surgery	Results/Degree of Recovery

**NOTE:** As part of our routine underwriting procedure, you may receive a phone call from the Home Office. The purpose of this call is to obtain information needed to evaluate and help speed the processing of your enrollment form. Your answers will be strictly confidential.

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**WAIVER OF COVERAGE**

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

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

- Declining **all** group coverage offered by my employer at this time
- Medical coverage declined for:       Employee       Spouse       Child(ren)
- Dental coverage, if available, declined for:       Employee       Spouse       Child(ren)

**Reason for declining coverage:**

- Covered by Spouse's Group Health Plan       Government Plan
- Individual Medical Plan       Medicare
- COBRA/State Continuation       Medicaid
- Not Affordable       State Plan
- Other (explain) \_\_\_\_\_

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**AGREEMENT AND AUTHORIZATION**

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

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

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

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

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

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

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

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

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

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

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **IMPORTANT NOTICE: PLEASE DETACH AND READ**

### **PRE-EXISTING CONDITION LIMITATIONS and SPECIAL ENROLLMENT RIGHTS**

#### **Pre-existing Condition Limitation**

This group health plan contains a pre-existing condition exclusion 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 the involuntary loss of other coverage. In addition, if your current coverage changes or you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

#### **Late Enrollees**

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. The pre-existing condition limitation above applies.

# THIS FORM MUST BE LEFT WITH ALL APPLICANTS

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

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

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

## **Introduction**

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

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

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

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

## **Permitted/Required Uses and Disclosures of PHI**

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

### *Use and Disclosure for Treatment*

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

### *Use and Disclosure for Payment*

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

### *Use and Disclosure for Health Care Operations*

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

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

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

#### *Other Permitted/Required Uses and Disclosures of PHI*

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

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

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

#### **Other Uses and Disclosures of PHI**

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

#### **Your Individual Rights With Respect to PHI**

Upon written request, you have the right to:

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

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

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

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

**Our Duties Regarding the Use and Disclosure of PHI**

We are committed to maintaining your privacy and are required:

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

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

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

Up to date privacy notices are maintained on our Website.

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

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

**How to Contact Us**

You may contact our representative at the following:

Privacy Officer  
HIPAA Compliance Department  
Trustmark Insurance Company  
P.O. Box 7961  
Lake Forest, IL 60045-7961  
Email – [HIPAAComplianceDepartment@trustmarklife.com](mailto:HIPAAComplianceDepartment@trustmarklife.com)  
Website – [www.trustmarklife.com](http://www.trustmarklife.com)