

Quick. Convenient. Secure.

# Health Plan Enrollment Made Easy

## **EXPRESS CONNECT: TELEPHONE ENROLLMENT GUIDE FOR EMPLOYEES**

Express Connect® streamlines your health plan enrollment process. You simply call a toll-free number to enroll. It's that easy.



## What You Need to Do

- 1. Before calling,** gather medical and prescription information that is pertinent to you, your spouse and dependent(s).
- 2. Read this guide.** You will be asked to indicate whether you have read and understand the notices and agreements on pages 3 and 4 of this guide before you can proceed with the enrollment process.
- 3. Make the call.** Call Starmark at a time convenient for you. You must call regardless of whether you are enrolling for or waiving coverage being offered by your employer. At the conclusion of the call, you will be asked to acknowledge that you are signing the enrollment form electronically, and you will be asked to answer a few questions to complete enrollment.

## What You Can Expect

- **Knowledgeable and friendly staff.** A client service representative will answer your call during your group's scheduled enrollment period.
- **Confidentiality.** Information you provide during enrollment is protected for your privacy. Starmark fully complies with the privacy protections of the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations. To view Starmark's Privacy Notice and complete privacy policy, visit the Privacy section of the website at [www.starmarkinc.com](http://www.starmarkinc.com).
- **Statement mailed to your home.** Once your employer accepts the Starmark offer, a copy of your Employee Eligibility Statement will be mailed directly to your home address.

# Information Needed for the Call

There are two main categories of information collected during the call: enrollment and medical information. To ensure your phone enrollment process goes smoothly, please have the following information available prior to calling Starmark.

## Enrollment Information

- Your employer's name and location
- If you are waiving coverage, you will be asked to provide the reason.
- If you are currently covered through COBRA or state continuation, you will be asked:
  - The termination date of employment: \_\_\_\_\_
  - Reason COBRA or state continuation was offered: \_\_\_\_\_
- The following employee, dependent spouse and dependent children information is required. Note: Social Security numbers are required for all covered employees and their dependents due to reporting requirements mandated in the Medicare, Medicaid and SCHIP Extension Act.
  - Employee demographics: Legal name, address, Social Security number, birth date, marital status, home and work phone, e-mail address, date employed full time, job title, hours worked per week and annual salary.
  - Spouse and dependent demographics: Spouse's legal name, Social Security number, occupation and birth date; dependent legal name(s), Social Security number(s) and birth date(s). Note: A dependent child is an unmarried child to age 25 (26 in GA and UT).
  - The effective and termination dates for prior coverage within the last 12 months.

## Medical Information

Please make sure the following information is available for each person, including dependents, applying for coverage. Use this worksheet to help you prepare for your enrollment call.

- Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form in the last 12 months?
  - Self:         Yes      No
  - Spouse:     Yes      No
- Current prescription drug usage, including name of drug, condition prescribed for and dosage. Having the prescription bottles on hand will be helpful, or you may wish to complete the grid below prior to your call.

Legal Name/Relationship to Employee	Drug Name	Prescribed for Which Condition	Drug Dosage	Frequency Taken	Date First Used

- You will be asked the height and weight of you and your spouse.
- You will be asked if you or any dependent has been diagnosed, treated, tested, or advised treatment or drugs for the conditions listed below in the past **four** years:
 

<input type="checkbox"/> Alcohol abuse or alcoholism, or drug abuse	<input type="checkbox"/> Liver
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mental or emotional
<input type="checkbox"/> Back	<input type="checkbox"/> Muscular
<input type="checkbox"/> Colon	<input type="checkbox"/> Neurological
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Reproductive organs
<input type="checkbox"/> Heart or circulatory (other than high blood pressure)	<input type="checkbox"/> Respiratory
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Seizures
<input type="checkbox"/> Immune deficiency disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Intestinal	<input type="checkbox"/> Systemic
<input type="checkbox"/> Kidney	<input type="checkbox"/> Tumor/cancer
- You will be asked if you or any dependent has been hospitalized, had surgery, had more than \$5,000 in medical expenses in the last 12 months or has been advised that hospitalization or surgery is necessary.
- You will be asked if you or any dependent is pregnant and the subsequent due date.

## Medical Information (continued)

You may also be asked to answer the following questions:

- Within the last **four** years, have you or any dependent received or been scheduled to have treatment and/or drug(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following:
 

<input type="checkbox"/> Allergy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Breast	<input type="checkbox"/> Prostate
<input type="checkbox"/> Digestive system	<input type="checkbox"/> Rectal
<input type="checkbox"/> Ear	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Eye	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Headache	<input type="checkbox"/> Urinary tract
- Within the last **four** years, have you or any dependent received or been scheduled to have treatment and/or drug(s), or been advised to receive treatment for any reason not already mentioned?     Yes     No

If you answer "Yes" to any of the conditions or questions above, you will be asked to provide additional information. The additional information requested would follow the format below, which you may wish to complete prior to your call:

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

## Beneficiary Designation

Your employer may select life insurance coverage. If life insurance is chosen as a benefit, you will be asked to designate a beneficiary.

## Notices and Agreements

During your call, you will be asked to verify that you read and understood the following agreements and notices.

### Medical Authorization

Unless waived, 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. I understand 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.

I authorize Trustmark Life Insurance Company (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 necessary.

### Risk Assessment

Any information on this enrollment and medical statement form is attached to and considered a part of the application, and will be relied on by Trustmark and Starmark for purposes related to underwriting coverage.

### 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

## Pre-existing Condition Limitation (cont.)

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 healthcare program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, governmental plan, 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 be able to enroll yourself or your dependents in this plan in the future, provided you request enrollment within 31 days after the involuntary loss of other coverage. Plus, if your current coverage changes or you have a life-changing event, such as a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided 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 applies.

## State-Specific Rules

State-specific rules apply for the following:

### Pre-existing Condition Limitation

**AK:** The break in coverage is 90 days.

**GA:** The break in coverage is 90 days.

**ID:** The pre-existing condition limitation is 12 months for late enrollees.

**IL:** Creditable coverage also includes Social Security and State Children's Health Insurance Program.

**IN:** The pre-existing condition limitation is 9 months; 15 months for late enrollees.

**KS:** The pre-existing condition limitation is 90 days.

**MI:** There is a 90-day affiliation period. No pre-existing condition limitation.

**NV:** Creditable coverage includes a blanket student accident policy.

**NM:** The pre-existing condition limitation is 6 months; 18 months for late enrollees.

**OH:** The pre-existing condition limitation is 12 months for late enrollees.

**PA:** The pre-existing condition limitation is 12 months for late enrollees.

**VA:** The pre-existing condition limitation is 12 months for late enrollees.

**WY:** The break in coverage is 90 days.

The information provided or requested within this telephone enrollment guide may vary by state.

Starmark's sole focus is providing a flexible healthcare benefits portfolio and unparalleled personal service to small businesses. By offering HSA-compatible health plans and nationwide network access, plus cutting-edge resources such as seamless HRA administration, easy and innovative paperless employee enrollment and valuable online healthcare decision support tools, Starmark continues to be a distinguished leader in small group healthcare benefits.



Plan availability and/or coverage may vary by state. Plans administered by Starmark are fully insured by Trustmark Life Insurance Company.

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