Administered by
Starmark®

400 Field Drive • Lake Forest, IL 60045-2581

Fully insured by
Trustmark
LIFE INSURANCE COMPANY

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 _____ Group No. _____
State ZIP

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	Social Security Number*	Birth Date	Marital Status
❑ Male ❑ Female			❑ Single ❑ Married

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

Date Employed Full Time _____ (mm/dd/yyyy) 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)

Beneficiary Name	First	M.I.	Last	Relationship

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	SEX F
Spouse	Occupation			❑	❑
Child				❑	❑
Child				❑	❑
Child				❑	❑
Child				❑	❑

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.

WAIVER OF COVERAGE

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

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

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

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

Reason for declining coverage:

❑ Covered by Spouse's Group Health Plan	❑ Government Plan
❑ Individual Medical Plan	❑ Medicare
❑ COBRA/State Continuation	❑ Medicaid
❑ Not Affordable	❑ State Plan

❑ Other (explain) _____

AGREEMENT AND AUTHORIZATION

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

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

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

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

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

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

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

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

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

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

Employee Signature _____ **Date** _____