

**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: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information commits insurance fraud, which is a crime subject to civil and criminal penalties.**

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	Social Security Number*	Birth Date
<input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status		
<input type="checkbox"/> Single <input type="checkbox"/> Married		

Work Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Date Employed Full Time \_\_\_\_\_ Job Title \_\_\_\_\_  
mm/dd/yyyy  
 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

**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 25.

**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**

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 been diagnosed as having or have been or are being treated for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, 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

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 for Comprehensive Medical Coverage.**

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 without regard to health-status related factors. 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. 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)