400 Field Drive • Lake Forest, IL 60045

Employee Eligibility Statement

To be completed by the EMPLOYEE ONLY. Print legibly in ink only. If you make a mistake when completing an answer, please correct, initial and date.
NOTICE: The Plan may rescind you or your dependent's coverage if you complete this form with false, incomplete or misleading information.

Employer Information

Company Name	Location (State, ZIP)	Group Number (If available)

Plan Choice (if available): Deductible	Physician/Hospital Network	Proposed Effective Date

Employee Information (All full-time employees must complete this section.)

First Name	Middle Initial	Last Name		
Address	City		State	ZIP
Sex ☐ Male ☐ Female	Social Security Number	Birth Date (mm/dd/yyyy)	Marital Status ☐ Single ☐ Married	
Work Phone	Home Phone	E-Mail Address		
Date Employed Full Time (mm/dd/yyyy)	Job Title	Hours Worked Per Week	Annual Salary $	

If selecting life insurance/accidental death and dismemberment coverage, the following beneficiary information is required.

Beneficiary Information (If applicable)

Beneficiary Name: First	M.I.	Last	Relationship

Coverage Information

Please check the appropriate boxes under either the "Applying for Coverage" section or the "Waiving Coverage" section. NOTE: If you are declining coverage and choose to apply for coverage in the future, you or your dependents may be considered late enrollees. Please see information regarding pre-existing conditions.

Applying for Coverage

Coverage applying for (Check only one):
- ☐ Employee only
- ☐ Employee and Spouse/Domestic Partner
- ☐ Employee and Child(ren)
- ☐ Employee, Spouse/Domestic Partner and Child(ren)

Reason for enrollment (Check only one):
- ☐ New Group Plan
- ☐ New Hire
- ☐ Plan Change
- ☐ Late Enrollment
- ☐ Special Enrollee (include Special Enrollee Form AD41)

If no longer employed, but on COBRA or State Continuation, enter employment termination date (mm/dd/yyyy): ______________________________

Waiving Coverage

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

☐ Medical coverage declined for:
☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ Dental coverage, if available, declined for:
☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

I have been offered medical coverage and wish to decline for the following reasons (check one below):
- ☐ Covered by spouse/domestic partner's group health plan
- ☐ Covered by government plan:
  ☐ Medicare ☐ Medicaid ☐ State plan
- ☐ Covered by Individual Medical Plan
- ☐ Not Affordable
- ☐ Covered by **COBRA/State Continuation***
- ☐ Other (explain): ______________________________

Employee Signature (if waiving coverage):

Signature: ______________________________ **Date:** ______________

***NOTE: If you are declining coverage for any reason other than COBRA/State Continuation, please complete this section, sign above and return the application. If you are declining coverage due to COBRA/State Continuation, please complete the entire eligibility statement.**

OFFICE USE ONLY

UND ______________________ EFF ______________________ SUB ______________________

Dependent Information

List the dependents to be covered. NOTE: If you are waiving coverage for your dependents, please complete the **Coverage Information** section on the first page.

Spouse/Domestic Partner First Name	Last Name	Birth Date (mm/dd/yyyy)	Social Security Number	Sex ☐M ☐F
Child First Name	Last Name	Birth Date (mm/dd/yyyy)	Social Security Number	Sex ☐M ☐F
Child First Name	Last Name	Birth Date (mm/dd/yyyy)	Social Security Number	Sex ☐M ☐F
Child First Name	Last Name	Birth Date (mm/dd/yyyy)	Social Security Number	Sex ☐M ☐F

Prior/Other Coverage

Did you or any dependent(s) enrolling on this form have prior major medical coverage within the last 12 months?
☐ Yes ☐ No If "yes", complete this section:

Prior Carrier Name____________________ Start Date ___/___/___ End Date ___/___/___

Who was covered? ☐ Employee ☐ Spouse/Domestic Partner ☐ Children

Do you or any dependent(s) enrolling on this form have existing major medical coverage that will remain in effect on the day this coverage begins?
☐ Yes ☐ No If "yes", complete this section:

Name of Other Carrier____________________ Start Date ___/___/___

Who is covered? ☐ Employee ☐ Spouse/Domestic Partner ☐ Children

Medical Information

Section A: The following questions apply to all enrolling (this includes employees, dependents and individuals on COBRA/State Continuation).

Have you or your spouse/domestic partner who will be covered used any tobacco products in the past 12 months? Employee: ☐ Yes ☐ No
Spouse/Domestic Partner: ☐ Yes ☐ No

Employee's Height	**Weight**	**Spouse/Domestic Partner's (if applicable) Height**	**Weight**

1. **Within the last four years** have you or any dependents who will be covered, consulted, received treatment or been advised to have treatment, had medication prescribed, or been diagnosed for any of the following? ☐ **Yes** ☐ **No** If "yes," check all that apply:
   - A. ☐ alcohol or drug use
   - B. ☐ arthritis
   - C. ☐ autoimmune disorder or systemic disease
   - D. ☐ back
   - E. ☐ cancer or tumor
   - F. ☐ diabetes
   - G. ☐ growth disorder or other endocrine/hormone disorder
   - H. ☐ heart or circulatory (other than high blood pressure)
   - I. ☐ muscular or joint
   - J. ☐ kidney
   - K. ☐ liver
   - L. ☐ lupus
   - M. ☐ mental or emotional disorder, including ADHD/ADD
   - N. ☐ colon or intestinal
   - O. ☐ respiratory
   - P. ☐ reproductive disorder
   - Q. ☐ neurological or stroke
2. Are you or any dependents who will be covered pregnant? ☐ **Yes** ☐ **No** If "yes," due date? __________
3. Have you or any dependent who will be covered 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**
4. Have you or any dependent who will be covered 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**

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.**

5. **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

6. **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**

Please provide complete details to all medical questions that have been checked or answered "Yes" on Page 3.

Medical Information

Employee Name: ______________________ Group: ______________________

Please provide details for each YES answer on Page 2 of the eligibility statement. If more space is needed, attach a separate sheet, sign and date it.

Question Number __________

Person with condition: ______________________ **Exact Diagnosis:** ______________________
Date diagnosed: ______________________ **Date last treated:** ______________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

List all treatment received for this condition: ______________________
List all tests received for this condition: ______________________ Readings and results: ______________________
Any relapses or flare ups? ☐ **Yes** ☐ **No** **Date(s):** ______________________
What future test, treatment, surgeries have been recommended? ______________________
Anticipated Date(s): ______________________
Prognosis: ______________________ Date last treated: ______________________

Question Number __________

Person with condition: ______________________ **Exact Diagnosis:** ______________________
Date diagnosed: ______________________ **Date last treated:** ______________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

List all treatment received for this condition: ______________________
List all tests received for this condition: ______________________ Readings and results: ______________________
Any relapses or flare ups? ☐ **Yes** ☐ **No** **Date(s):** ______________________
What future test, treatment, surgeries have been recommended? ______________________
Anticipated Date(s): ______________________
Prognosis: ______________________ Date last treated: ______________________

Question Number __________

Person with condition: ______________________ **Exact Diagnosis:** ______________________
Date diagnosed: ______________________ **Date last treated:** ______________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

List all treatment received for this condition: ______________________
List all tests received for this condition: ______________________ Readings and results: ______________________
Any relapses or flare ups? ☐ **Yes** ☐ **No** **Date(s):** ______________________
What future test, treatment, surgeries have been recommended? ______________________
Anticipated Date(s): ______________________
Prognosis: ______________________ Date last treated: ______________________

As part of our routine underwriting procedure, you may receive a telephone call from the home office to obtain additional information needed to evaluate your Eligibility Statement. Providing additional medical information on this form will help reduce the need for a phone call. Your answers will be strictly confidential.

SIGNATURE AND DATE ARE REQUIRED ON THE AGREEMENT AND AUTHORIZATION SECTION. PLEASE CONTINUE TO NEXT PAGE.

AGREEMENT AND AUTHORIZATION

Unless waived on Page 1, I request coverage under my employer's 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 eligibility statement 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 will be valid for 60 days from the date signed.

Star Marketing and Administration, Inc. (Starmark) may obtain and maintain Protected Health Information (PHI) or Personal Information about you to perform specific functions. This Authorization describes the type of information that is collected and your rights regarding how that information can be used.

Starmark is committed to the privacy of your PHI/Personal Information and has 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, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be Protected Health Information and/or Personal Information.
Protected Health Information (PHI) includes individually identifiable health information that is created or received by your provider, health plan or insurer, data clearinghouse, a health authority, employer, school or university.

Personal information includes individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about your character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. Personal Information does not include information that both relates to a claim or civil or criminal proceeding and is collected in reasonable anticipation of same.

PHI/Personal Information 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/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability Act 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 you or your health care providers, referrals made by health care providers, and your medical records. Other sources of PHI/Personal Information 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/Personal Information may be obtained, maintained, or transmitted in any form or medium, including over the telephone, by mail, or e-mail.

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

I authorize Starmark and Its consumer reporting agencies, or any of its authorized representatives to obtain, use, and/or disclose certain Information about me as Indicated above.

I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed.
I understand that failure to sign this Authorization will result in my application not being considered.
I understand that my Personal Representative or I have a right to receive a copy of the authorization form.

I agree this Authorization will be valid until Starmark has completed its determination of my eligibility for coverage or for 12 months from the date signed, whichever is less.

A simulated, faxed or copied image of this Authorization shall be as valid as the original.

If this Employee Eligibility Statement was completed by electronic or telephonic means, I acknowledge that I have not myself actually signed the Employee Eligibility Statement but instead I hereby authorize Starmark or its Agent to print "Electronically Acknowledged" on the signature line of the Employee Eligibility Statement and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that Starmark or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation.

Employee Signature ______________________________ Date ________________

IMPORTANT NOTICE: PLEASE DETACH AND READ

PRE-EXISTING CONDITION LIMITATIONS and SPECIAL ENROLLMENT RIGHTS

Pre-existing Condition Limitation

Your employer's health plan contains a pre-existing condition exclusion for persons ages 19 and older that is limited to a maximum of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy including a short term plan, Medicare, Medicaid, CHAMPUS, Federal Employees Health Benefit Plan (FEHBP), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, governmental plans, church plan or a health plan issued under the Peace Corps Act. 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.

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after coverage was terminated as a result of loss of eligibility for the coverage or termination of employer contribution (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). In addition, if your current coverage changes or you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

Late Enrollees

If you waive coverage at the original effective date of your employer's plan and do not qualify as a special enrollee, coverage will start as follows:

- If your employer's plan has been in force for less than 12 months, coverage will start on the plan's first anniversary.
- If your employer's plan has been in force for 12 months or more, coverage will start on the first day of the month following the date the Employee Eligibility Statement 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 Eligibility Statement 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.

TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK
(We, Us, Our)

NOTICE OF PRIVACY PRACTICES

Effective date of this notice: February 13, 2012

Our Commitment to Protecting Your Privacy

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

You do not need to respond to this notice in any way.

Our Responsibilities and Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

- Maintain the privacy of your personal information.
- Provide you with certain rights with respect to your personal information.
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information.
- Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

Information We Collect

Personal Information is any information we obtain about you in the course of issuing insurance and/or providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical or mental health or condition, the provision of health care to you, payment for the provision of health care to you, your Social Security number, employment history, credit history, income information, and bank or credit card information.

We obtain this information from several sources, including but not limited to applications or other forms you complete, your business dealings with us and other companies, and consumer reporting agencies.

Our Privacy and Security Procedures

Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our insureds.
- Our business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow our privacy procedures.

Information We Disclose

We will not disclose any Personal Information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes.

- Underwriting;
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;
- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.

Your information may also be shared:

- For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.
- With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.
- In response to an administrative or judicial order, including a search warrant or subpoena.
- With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.
- To conduct actuarial or research studies. In this case, individuals are not identified in the research report. Material identifying an individual is destroyed as soon as it is no longer needed.
- With our business associates for use in auditing services or operations, auditing marketing services, performing various functions on our behalf, or to provide certain services.
- With a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.
- To consult with outside health care providers, consultants and attorneys, and other health related services.
- As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your Personal Information. We share only that which is minimally necessary to accomplish a task. Information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes.

Your written authorization is required for uses and disclosures of Personal Information for purposes other than those described above. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your Personal Information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Your Rights

Upon written request, you have the right to:

- Inspect and copy certain Personal Information. We may charge a reasonable fee for the costs of copying or mailing.
- Receive confidential communication of Personal Information.
- Request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction.
- Request an amendment to your Personal Information, although we are not required to agree to an amendment.
- Receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with federal law (or state regulations, if applicable) for which an accounting is required.
- Be notified of a breach of unsecured Personal Information.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

How to Contact Us

You may contact our representative at the following address:

Privacy Officer
Privacy Request
Trustmark Companies
PO Box 7961

Lake Forest, IL 60045-7961

Email – privacymanagementoffice@trustmarkins.com

Notification of a revised privacy notice will be provided through one of the following:

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

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used Trustmark Mutual Holding Company or its subsidiaries and affiliates.