Trustmark
GROUP SELECT

Trustmark Life Insurance Company
Enrollment and Medical Statement

Helpful Tips

1) Please sign and date form on page 5. Each employee, spouse/domestic partner and dependent age 18 or over should sign and date this form on page 5.
2) Please print all information.
3) 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 any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Group Name (Employer): ______

Employee Name: ______
First Middle Initial Last

Social Security #: ______ E-mail Address: ______

Address: ______
City State Zip Code

Home Phone #: ______ Sex: ☐ M ☐ F

Date of Birth: ______ (mm/dd/yyyy) Height: ______ ft. in. Weight: ______ lbs.

Marital Status: ☐ Single ☐ Married

Date of Full-Time Employment: ______ (mm/dd/yyyy) Hours Worked Per Week: ______

Occupation: ______ ☐ Hourly ☐ Salaried

Please check the appropriate boxes under either the "Applying For Coverage" section or the "Waiving Coverage" section.

Applying For Coverage	Waiving Coverage
I am applying for coverage ☐ **Yes** ☐ **No**	**I am waiving coverage** ☐ **Yes** ☐ **No**
If any of the following apply, please check the box below. ☐ New Hire ☐ Special Enrollee ☐ Late Enrollee ☐ Reinstatement ☐ COBRA Continuee If a Cobra continuee, indicate date started and reason: ______ Are you covered under any other Medical Insurance Plan? ☐ Yes ☐ No *NOTE: If you are a special enrollee, please attach your Certificate of Creditable Coverage*	I have been offered medical coverage and wish to waive coverage for the following reasons: ☐ Covered by Spouse's Domestic Partner's Group Health Plan ☐ Individual Medical Plan ☐ Medicare ☐ Medicaid ☐ Other (please explain) ______ ☐ COBRA (state continuation) *NOTE: If you are waiving coverage, sign and date form on page 5*

Dependent Spouse/Domestic Partner Name: ______
First Middle Initial Last

Social Security #: ______

Sex: ☐ M ☐ F Date of Birth: ______ Height: ______ ft in. Weight: ______ lbs.

Is your Dependent Spouse/Domestic Partner covered under any other Medical Insurance Plan? ☐ Yes ☐ No

THIS BOX TO BE COMPLETED BY GROUP ADMINISTRATOR					
Group #:	Division #:	Class:	Dept.:	Location Code:	Effective Date:

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Employee Name: ______________________

Dependent Child(ren) Names:	Social Security #	Birth Date mm/dd/yy	Sex	Check any that apply: Full-Time Student	Natural/ Adopted	Step-child	Other	Covered under any other medical plan?
			☐ M ☐ F	☐	☐	☐	☐	☐
			☐ M ☐ F	☐	☐	☐	☐	☐
			☐ M ☐ F	☐	☐	☐	☐	☐
			☐ M ☐ F	☐	☐	☐	☐	☐
			☐ M ☐ F	☐	☐	☐	☐	☐

ENROLLMENT INFORMATION

Medical Plan Applying For: ☐ Group Select PPO ☐ Group Select HSA ☐ Group Select HRA

Deductible Amount Selected (if more than one option offered): $

Physician/Hospital Network Selected (if more than one option offered):

	Employee Applying	Employee Waiving	Spouse/Domestic Partner Applying	Spouse/Domestic Partner Waiving	Child(ren) Applying	Child(ren) Waiving
Medical	☐	☐	☐	☐	☐	☐
Dental	☐	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐	☐
Life/AD&D	☐	☐				
Short Term Disability	☐	☐				
Long Term Disability	☐	☐				
Optional Life/Dependent Life	☐	☐	☐	☐	☐	☐

Employee Optional Life Amount: $ ______________

If applying for Life and/or Optional Life please indicate Beneficiary Designation:

Full Name: ______________________ Relationship ______________

If applying for Disability or Optional Life please indicate:

Base Annual Salary: $ ______________

Note: (Coverage can be waived only if you pay part or all of the premium.)

MEDICAL QUESTIONS

1. Have you or your Spouse/Domestic Partner smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months?
   - Employee ☐ Yes ☐ No
   - Spouse/Domestic Partner ☐ Yes ☐ No

2. Prescription Medication: Do you or your dependents currently take prescription medications? ☐ Yes ☐ No

   If yes, please fill in the grid below

Name/Relationship to Employee	Name of Medication	Condition prescribed for	Dosage of the medication	How often taken?	First date you took prescription?

As you complete the grid above for the prescription medications you or your dependents currently take daily or periodically, it may be helpful to read the information from the medication bottle or container.

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Employee Name: ____________________

3. Medical Conditions: Please indicate if you or any dependent to be covered under your employer's benefits plan have/has in the past 3 years been diagnosed with, or treated by, a member of the medical profession for the conditions listed below. If "Yes" is checked for any conditions, please complete the grid that follows the list with information pertaining to that diagnosis and treatment.

The applicant does not have to disclose an HIV (AIDS) Virus test, a test to determine the presence of blood borne pathogens, or a test to determine the presence of the Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV), which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical person(s) who were tested as a result of performing emergency medical services. Refer to the Medical Authorization section of this application for the definition of "emergency medical personnel" and "blood borne pathogens."

Condition	Yes	No
a. AIDS		
b. Alcohol or drug abuse treatment		
c. Blood disorder (including hemophilia and anemia)		
d. Bone/joint/muscle disorder (including arthritis, back/spine, physical deformity, or birth defect)		
e. Cancer (including leukemia, Hodgkin's disease, melanoma and lymphoma)		
f. Diabetes, if yes, list last blood sugar or A1C reading here:		
g. Digestive/Intestinal disorder (including colon, Crohn's disease or ulcerative colitis)		
h. Endocrine, adrenal, or pituitary disorder		
i. Heart/circulatory disorder(s)/chest pain		
j. High blood pressure, if yes, list last 3 readings here:		
k. Immune deficiency disorder		
l. Kidney/liver/pancreas disease (including cirrhosis and hepatitis)		
m. Mental/nervous/behavioral disorder		
n. Neurological disorder (including cerebral palsy, multiple sclerosis, cystic fibrosis, stroke and paralysis)		
o. Reproductive/infertility/genitourinary disorder		
p. Respiratory/lung disorder (including but not limited to COPD and Emphysema)		
q. Tumor		
Additional questions on medical conditions:	**Yes**	**No**
r. Are you or any dependent to be covered under your employer's benefits plan currently pregnant? If yes, list due date in last column of the grid below. Please indicate details below if there are or have been in the past, complications, premature birth, multiple gestation or c-section.		
s. Have you or any dependent to be covered under your employer's benefits plan incurred more than $10,000 in medical expenses in the past 12 months?		

If you answered "Yes" to any of the conditions or questions above, please provide additional information in the grid below.

Question letter	Name/Relationship to Employee	Date of condition's onset	Date last seen by a physician for this condition	What is the recovery status?	Describe specific diagnosis for the noted condition. Also, if a medical procedure was performed or advised, indicate type of procedure.

Please use the blank section at the bottom of page 5 to record additional information as necessary

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Employee Name: ______________________________

AGREEMENTS

The answers and statements on this Enrollment and Medical Statement are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by Trustmark at its Home Office. I have read, or have had read to me, the completed Enrollment and Medical Statement and I realize that any false statements or misrepresentation in the Enrollment and Medical Statement may result in loss of coverage under the contract. The information on this form shall replace any previously dated forms that may be on file.

MEDICAL AUTHORIZATION

I authorize any of the following to disclose to Trustmark Life Insurance Company, Lake Forest, Illinois, any data it has on me or my health or on the health of my family: (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) the Medical Information Bureau; (5) pharmacies and pharmacy benefits management companies; or (6) any other organization, institution or person that has data on me or my health or on the health of my family. I specifically authorize the release of information on alcohol or drug abuse and mental illness. I also authorize such disclosure of data to the reinsurer or Trustmark Life Insurance Company. I waive, to the extent allowed by law, all provisions of law forbidding such disclosure. I make such waiver on behalf of myself and any person who shall have or claim any interest on any insurance issued hereon. A copy of this shall be as valid as the original. This authorization will remain valid for 12 months from the date it is signed.

When applying for multiple coverages through Trustmark under the same application or enrollment form (for example medical coverage with a life and/or disability income benefit), your personal information will be shared internally between those products for the purpose of administering all benefits. All information is held to the same privacy standards and is not used or disclosed unless required or permitted by law.

This authorization excludes the release of information about HIV (AIDS) Virus test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law. The term **"emergency medical person(s)"** includes individuals employed or receiving compensation to provide out-of-hospital emergency medical services such as licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of ambulance services who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience significant exposure to an inmate who is transported to a facility for emergency medical care; licensed peace officers; individuals who, while making a citizen's arrest, may have experienced exposure to a source individual; and other person who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law. The term "**blood borne pathogens**" means pathogenic microorganisms that are present in the human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV). The term "**source individual**" means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of blood borne pathogen exposure to an emergency medical services person. Examples include, but are not limited to, a victim of an accident, injury or illness, or a deceased person. The term "**significant exposure**" means contact likely to transmit a blood borne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes: (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a blood borne pathogen, with blood, tissue, or potentially infectious body fluids.

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 for purposes related to underwriting the coverage.

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

In compliance with Public Law 91-508, information regarding your insurability will be treated as confidential. Trustmark Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information on you it may have on file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, Massachusetts 02112, telephone number: 1(617)426-3660.

Trustmark Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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Employee Name: ______________________________

SPECIAL ENROLLMENTS

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) 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 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

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) from the first day of coverage or of the waiting period, if any. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period which ends on the day before your coverage or the waiting period, if any, begins. This exclusion period may be reduced by the number of days of your prior creditable coverage. 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 certification(s) of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, State Children's Health Insurance Program (S-CHIP), 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 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.

You may contact us if you need additional information or assistance. All questions about pre-existing condition exclusions and creditable coverage should be directed to Trustmark Customer Service at 1(800)544-7312.

I wish to apply for all coverages as indicated above for which I am eligible under the group contract. I authorize payroll deductions for my share, if any, of the costs of the coverages applied for.

I understand that in the event I desire at a later date, such coverages, previously canceled or refused, I will be required to furnish an Enrollment and Medical Statement and may be subject to an 18-month pre-existing condition exclusion.

Employees, and any spouse/domestic partner or dependent over the age of 18 for whom you are applying for coverage, please sign below.

______________________________ ______________________________
Signature of Employee Date

______________________________ ______________________________
Signature of Spouse/Domestic Partner Date

______________________________ ______________________________
Signature of Dependent (age 18 or over) Date

______________________________ ______________________________
Signature of Dependent (age 18 or over) Date