



EMPLOYEE ENROLLMENT FORM

To be completed by the employee only

Type or print with ink

Note: If you make a mistake when completing an answer, please correct and initial

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 Family Addition Late Enrollment Reinstatement Plan Change

EMPLOYER INFORMATION

Group Name _____	Group No. _____
------------------	-----------------

EMPLOYEE INFORMATION

Name	First _____	M.I. _____	Last _____		
Home Address	Street _____	City _____	State _____	Zip Code _____	
Sex	Social Security Number _____	Birthdate _____	Marital Status		
<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Single <input type="checkbox"/> Married		

Work Phone (_____) _____ Home Phone (_____) _____

Date Employed Full-Time _____ Job Title _____

Hours worked per week _____ Annual Salary \$ _____

If no longer employed, but on COBRA/Continuation, enter employment termination date _____

Beneficiary Name	First	M.I.	Last	Relationship
------------------	-------	------	------	--------------

DEPENDENTS TO BE COVERED			SEX		Have you or your spouse used any tobacco products in the past 12 months? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
(First)	NAME (Last)	BIRTHDATE	M	F	
Spouse _____	Occupation _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Deductible \$ _____ Network _____ (When choice is available)
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 a child to age 19 or a full-time student to age 25.

PROOF OF PRIOR COVERAGE

Did you or your dependent(s) have **major medical** coverage with another carrier(s) within the past 12 months? Yes No

If yes, complete the following. (If insured with more than one carrier in 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) Self Spouse Child(ren)

OFFICE USE ONLY

UND _____ EFF _____ SUB _____

MEDICAL INFORMATION

Employee's _____
Spouse's (if applicable) _____
Height _____ Weight _____
Height _____ Weight _____

SECTION A: The following questions apply to ALL individuals for whom insurance coverage is requested.

1. Within the last 4 years, have you or any dependent received or been recommended to have treatment for, consulted a physician or other medical professional or had any test performed for any disorders or conditions of the following? Yes No

Please check all that apply.

- back
- stroke
- intestinal
- reproductive organs
- colon
- kidney
- muscular
- mental or emotional
- tumor/cancer
- diabetes
- respiratory
- systemic
- liver
- arthritis
- neurological
- heart or circulatory
- seizures (other than high blood pressure)

2. 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

3. 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

4. Have you or any dependent been hospitalized, had surgery, had more than \$5000 in medical expenses in the last 12 months or been advised that hospitalization or surgery is necessary? Yes No

5. 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.

6. Within the last 4 years, have you or any dependent received or been recommended to have treatment for, consulted a physician or other medical professional or had any test performed for any disorders or conditions of the following? Yes No

Please check all that apply.

- ear
- hernia
- thyroid
- urinary tract
- eye
- allergy
- prostate
- digestive system
- ulcer
- asthma
- headache
- high blood pressure
- rectal
- breast

7. Within the last 4 years, have you or any dependent received treatment 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, treatment, physician's name, address and phone number. Please indicate if complete recovery. (If additional space is necessary, attach a separate sheet, sign and date it.)

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 coverages offered by my employer and I have decided not to apply. I understand that if I choose to apply for this coverage in the future, my application may be subject to individual medical underwriting, and I may be required to furnish evidence of insurability at my own expense. I also understand that additional limitations and waiting periods may apply.

Waiving all group coverage offered by my employer at this time.

Medical coverage waived for: Employee Spouse Child(ren)

Dental coverage, if available, waived for: Employee Spouse Child(ren)

Reason for waiving coverage: Covered by spouse's insurance 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 hereby authorize any licensed physician; medical practitioner; hospital; clinic; any medical or medically related facility; insurance company; employer; Veteran's Administration; or consumer reporting agency to give Trustmark Insurance Company (Trustmark) and Star Marketing and Administration, Inc. (Starmark), or its authorized representatives, any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice, or treatment upon presentation of this authorization or photocopy thereof.

Trustmark or Starmark may release any information obtained to reinsuring companies, or other persons or organizations performing business or legal services in connection with this application, any claim, or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization will be valid for thirty (30) months from the date signed. I have read this authorization and have received a copy of the "Notice Under the Fair Credit Reporting Act". I or my authorized representative may obtain a copy of this form upon request.

Employee Signature _____ Date _____

**IMPORTANT NOTICE: PLEASE DETACH AND READ
NOTICE UNDER THE FAIR CREDIT REPORTING ACT**

In compliance with Public Law 91-508, an investigative consumer report may be made which will provide applicable and relevant material concerning character, general reputation, personal characteristics and mode of living of any persons to be covered. This report will be obtained through personal interviews with friends, neighbors, and associates. Upon written request to the Company, a complete and accurate disclosure of the nature and scope of the investigation consumer report, if one is made, will be provided.

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of information. You are our main source of information, but we may also collect or verify information by contacting: (1) medical professionals and institutions (which have provided care to you or members of your family proposed for coverage); (2) employers and business associates; (3) friends and neighbors; and (4) insurance companies you have applied to.

In some cases, disclosure of personal or privileged information may be made (without your authorization) to third parties. For example, we may disclose such information to: (1) persons or organizations which perform professional, business or insurance functions for us (such as independent claim examiners or group plan administrators); or (2) other insurance companies to which you have applied for coverage or benefits.

You have a right to access, correct, and amend personal information about you appearing in our files. (including information contained in investigative consumer reports). A more complete description of our information practices and your rights will be sent to you upon request.

You may request to be interviewed if an investigative consumer report is prepared, and you are entitled, upon request, to receive a copy of such report. To make these requests, please write to:

Trustmark Insurance Company

UW3 AZ (R2)

c/o Star Marketing and Administration, Inc. • 400 Field Drive • Lake Forest, Illinois 60045-2581

(6-00)

SPECIAL ENROLLMENT RIGHTS and PRE-EXISTING CONDITION LIMITATIONS

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of 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). 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, 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, 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.

**IMPORTANT NOTICE TO ALL PERSONS WAIVING
GROUP HEALTH INSURANCE COVERAGE**

This notice applies to all eligible employees or dependents who waive coverage at the original effective date of the group health plan administered by Starmark.

If you waive the group health insurance coverage offered by your employer for yourself or your dependents (including your spouse) at this time, you or your dependents may be considered late enrollees if you apply for coverage at a later date. If you are considered a late enrollee, your coverage will be delayed for 18 months (15 months in Indiana; 12 months in Idaho, Michigan, Pennsylvania and Virginia) following the date you sign the Employee Enrollment Form. A person is not a late enrollee if that person qualifies as a Special Enrollee. See the notice regarding Special Enrollment Rights attached to the Employee Enrollment Form.

Not applicable in Arizona, Kansas, Ohio or Texas.

THIS FORM MUST BE LEFT WITH ALL APPLICANTS.