Trustmark®
GROUP INSURANCE

Trustmark Life Insurance Company
Group Enrollment Form

INSTRUCTIONS: *Shaded portion (top) to be completed by the Employer. White portion to be completed by the employee. Print clearly in dark ink, sign the form and return as instructed.*

Group Name:	Group #:	Division:	Class:	Dept. Code:	Date of Hire:	Effective Date:

☐ New Enrollment
☐ Annual/Open Enrollment
☐ Reinstatement
☐ Add Newborn
☐ Add Spouse
☐ Change Personal Data
☐ Late Enrollee
☐ Special Enrollee *(Please attach certificate of Creditable Coverage)*
☐ Waive/Reduce Coverage

Employee Name (Last, First, MI):	☐ Male ☐ Female	Date of Birth:	Social Security Number:	Phone Number:
Employee Address (Street Address, City, State, Zip Code):			Email Address:	Number of hours worked per week:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Date of Marriage: ________________

Occupation:

Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months?
Self: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Are you covered by another health insurance plan?
☐ Yes ☐ No

MEDICAL PLAN APPLYING FOR *(select one)*:
☐ **PPO** ☐ **PPO/HRA** ☐ **PPO/HSA**
☐ **OPEN ACCESS** ☐ **INDEMNITY**

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

Coverage applying for:	Employee Only	Employee & Spouse	Employee & Child(ren)	Full Family	Waive Coverage*
Medical	☐	☐	☐	☐	☐
Dental	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐

Waiver of Coverage** ***(Coverage can be declined only if you pay part or all of the premium)

I have been offered the above coverage and wish to decline enrollment for the following reason(s):

☐ Covered under another group health plan
☐ Enrolled in other employer health plan
☐ Other *(please explain)*: ....
....
☐ Covered under a nongroup health plan

The information on this form shall replace any previously dated forms that may be on file.

THIS CARD WILL NOT BE ACCEPTED BY TRUSTMARK LIFE INSURANCE COMPANY UNLESS SIGNED AND DATED BY THE INSURED/EMPLOYEE.

COMPLETE ONLY IF APPLYING FOR DEPENDENT COVERAGE: *(Attach an additional page if necessary)*

Dependent's Full Name	Relationship	Sex	Social Security Number	Birth Date	Full-Time Student	Other Health Insurance
	☐ Spouse ☐ Common Law Spouse* ☐ Domestic Partner*	☐ M ☐ F			N/A	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No

****Please complete and attach the appropriate spousal/dependent verification form.***

I wish to apply for all coverages listed for which I am eligible under the group contract. I authorize payroll deductions for my share, if any, of the costs of coverage applied for. I understand that in the event I desire at a later date such coverages previously canceled or refused, I may be required to furnish a late enrollee form and may be subject to an 18-month pre-existing condition exclusion.

I certify that if enrolled under the PPO with HRA medical plan, I will only seek reimbursement for eligible medical expenses as described under the plan that have not been reimbursed or eligible for reimbursement under any other health plan, other insurance or from any other source.

________________________________ ________________
Employee Signature *Date*

PLEASE READ REVERSE SIDE FOR IMPORTANT INFORMATION REGARDING YOUR RIGHT TO SPECIAL ENROLLMENT AND PRE-EXISTING CONDITION LIMITATIONS.

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Employee Name (Last, First, MI):	☐ Male ☐ Female	Date of Birth:	Social Security Number:	Phone Number:
Employee Address (Street Address, City, State, Zip Code):			Email Address:	Number of hours worked per week:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Date of Marriage: ________________

Occupation:

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Are you covered by another health insurance plan?
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COMPLETE ONLY IF APPLYING FOR DEPENDENT COVERAGE: *(Attach an additional page if necessary)*

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	☐ Spouse ☐ Common Law Spouse* ☐ Domestic Partner*	☐ M ☐ F			N/A	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ____________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ____________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ____________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No
	☐ Natural/Adopted Child ☐ Stepchild* ☐ Other* ____________	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No

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I certify that if enrolled under the PPO with HRA medical plan, I will only seek reimbursement for eligible medical expenses as described under the plan that have not been reimbursed or eligible for reimbursement under any other health plan, other insurance or from any other source.

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______________________________ ______________
Employee Signature *Date*

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FRAUD WARNING

Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

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 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 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 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 healthcare 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 Boardman Benefits at (800) 544-7312.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) TAX MESSAGE

Your Health Reimbursement Arrangement will only reimburse eligible medical expenses as described under the plan which are not reimbursable from another medical plan, other insurance, or any other source. If you, your spouse or eligible dependents have secondary medical coverage with another carrier which you have not previously disclosed you should contact Healthy Foundations at (800) 285-7911 to document this information. If an expense has been reimbursed that is not an eligible medical expense under the plan you may be liable for payment of all related taxes including federal, state, or city income tax.