Administered by
Starmark®
A Trustmark Company
400 Field Drive • Lake Forest, IL 60045

For New Enrollees of Existing Groups

Employee Eligibility Statement

Coverage Applied For (Check only one): ☐ Major Medical Plan ☐ Preventive Care Plan (non-major medical)*

*** IMPORTANT NOTICE: This plan does not provide comprehensive major medical coverage; this plan covers preventive care services only. Benefits are limited.** This preventive care benefit plan currently fulfills an individual's requirement under the Affordable Care Act to maintain minimum essential coverage, subject to revision of applicable law, regulation and regulatory interpretation.

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 Company has the right to revise rates (retroactively or prospectively), rescind or terminate your employer's Stop Loss Insurance Contract if you complete this form with false, incomplete or misleading information. Your employer 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)	
PLAN CHOICE (if available): DEDUCTIBLE	**PHYSICIAN/HOSPITAL NETWORK**	**GROUP Number (If available)**

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

LEGAL FIRST NAME	MIDDLE INITIAL	LEGAL 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	EMPLOYEE E-MAIL ADDRESS	
DATE EMPLOYED FULL TIME (mm/dd/yyyy)	JOB TITLE	HOURS WORKED PER WEEK	ANNUAL SALARY $

Beneficiary Information - (Complete when employer is offering Life/Accidental Death & Dismemberment coverage)

BENEFICIARY NAME: First	M.I.	Last	Relationship
ADDRESS:	City	State	ZIP

Coverage Information - Please check in appropriate boxes

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
- ☐ Open/Late Enrollment
- ☐ Special Enrollee (include Special Enrollee Form AD41)

*** If the employer has designated eligibility for domestic partners, coverage may be included for a domestic partner as an eligible dependent.**

Waiving Coverage

☐ Declining **all** group coverage. I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

☐ Medical coverage declined for:

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ Fully Insured Dental declined for (if available):

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

I wish to decline for the following reasons (check one below):

- ☐ Covered by spouse/domestic partner's group health plan
- ☐ Government plan:
  - ☐ Medicare ☐ Medicaid ☐ State plan
- ☐ Individual Medical Plan
- ☐ Not Affordable
- ☐ **COBRA/State Continuation**
- ☐ Other (explain): _____

Employee Signature (if waiving coverage):

Signature: _____ **Date:** _____

✍ **ORIGINAL SIGNATURE REQUIRED. PRINT THEN SIGN.**

OFFICE USE ONLY

UND_____ EFF_____ SUB _____

Special Enrollee

If you are an employee or dependent(s) who previously waived coverage and now have **lost coverage**, **had a contribution change or a life-changing event, you may be considered a Special Enrollee. Starmark must receive these forms within 31 days of the special enrollment event.** Failure to submit your request within the 31 days could result in a delay in coverage.

Name of person(s) applying for coverage, if OTHER than the employee: ______________________________

Unless otherwise noted, you must provide supporting documentation within the 31 days of your special enrollment event. If you are unable to obtain the supporting documentation within the time frame allotted, please do not delay your enrollment request. We will hold your request until the necessary information is received. Once approved, you will be added to the plan as of your event date and premium will be charged accordingly.

☐ **Loss of Coverage (including occurrences due to entrance into the U.S.)**: Coverage Termination Date: ____________
MM/DD/YY

Type of Loss: ☐ Group Coverage ☐ Individual Coverage

Reason for Loss: ☐ Job termination ☐ No longer eligible – company policy (i.e., dependent coverage is no longer offered, etc.)

☐ Other ______________________________

☐ **Contribution Change:** Date of Change: ____________
MM/DD/YY

☐ Contribution (increase/decrease in employer contribution level)

☐ **Life-Changing Events:**

☐ Adoption of a child – Date of Placement: ____________

☐ Divorce – Date: ____________

☐ Marriage – Date: ____________ *Documentation is not required.*

☐ Birth of a child

☐ **Other**: Provide Detailed Explanation**:**

____

____

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 LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F

Other Coverage

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

Name of Other Carrier ______________________ Start Date ___/___/___

If Medicare check type of coverage: ☐ Part A Effective date:________ ☐ Part B Effective date:________ ☐ Part D Effective date: ________

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

SIGNATURE AND DATE ARE REQUIRED ON THE AGREEMENT AND AUTHORIZATION SECTION. **CONTINUED ON THE NEXT PAGE.**

Agreement to Enroll for Coverage

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 Employee 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.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

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.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare 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.

By signing this form, I authorize certain entities identified below to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

II. Purpose of the Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for my employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

I hereby authorize the following entities, their reinsurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above:

Star Marketing and Administration, Inc.

Trustmark Life Insurance Company

I authorize Entities to disclose my PHI between themselves and their affiliated companies, to reinsuring companies, to the plan administrator or plan sponsor.

I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including, but not limited to, all medical and healthcare records.

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.

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

IV. Term of Authorization

I further 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.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to the entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I AGREE THAT A FAXED OR COPIED IMAGE OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

☐ **YES, I AGREE TO RECEIVE EMPLOYEE BENEFIT DOCUMENTS INCLUDING, BUT NOT LIMITED TO: PLAN DOCUMENTS, SUMMARY PLAN DESCRIPTIONS, SUMMARY OF BENEFITS AND COVERAGE, POLICIES, CONTRACTS, AGREEMENTS, LETTERS AND NOTICES THROUGH ELECTRONIC MEDIA USING A COMPUTER WITH INTERNET ACCESS. I UNDERSTAND I CAN RECEIVE PRINTED DOCUMENTS AT NO COST AFTER I NOTIFY STARMARK OF MY CHANGE IN PREFERENCE.**

Employee Signature _____ Date _____

✍ **ORIGINAL SIGNATURE REQUIRED. PRINT THEN SIGN.**

IMPORTANT NOTICE: PLEASE READ AND RETAIN

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.

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.

The following notice applies to major medical coverage:

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast in which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits.

The following notice applies to preventive care coverage:

This plan does not provide comprehensive major medical coverage. Benefits are limited. This preventive benefits plan fulfills an individual's requirement under the Affordable Care Act to maintain minimum essential coverage, subject to revision of applicable law, regulation and regulatory interpretation.