Payroll Deduction Authorization

Employer: _____

Employee Name: _____

Employee SSN: _____Employee ID #: _____

Payroll Frequency:

- ☐ Weekly (52)
- ☐ Bi-Weekly (26)
- ☐ Semi-Monthly (24)
- ☐ Monthly (12)
- ☐ _____

Payroll Deduction to begin:

	Original Deduction Per Pay Period	Current Deduction Per Pay Period
Employee Coverage	$ _____	$ _____
Spouse Coverage	$ _____	$ _____
Dependent Child Coverage	$ _____	$ _____
Total	$ _____	$ _____

Pre-Authorized Additions:
I authorize increasing my deduction per pay period by an amount equal to $_____ Employee, $1.00 Spouse (Life) and/or $1.00 (Cancer) per week. The increase will take place after each 12-month period starting one year from the date of this authorization and stopping after the final increase. **(Check one):** ☐ Yes ☐ No

To Employer:
I authorize and request you to: 1) deduct from my salary the amount shown above; and 2) pay to Trustmark to cover premiums on the insurance for which I have applied. This authorization shall remain in effect until: 1) I give written notice to stop insurance; or 2) termination of my employment. The insurance will be effective on the date assigned by Trustmark.

I certify that I received no illustration in the sale of this life insurance policy. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

_____ _____
Employee Signature Date

I certify that no illustration was used in the sale of this life insurance policy.

_____ _____
Agent Signature Date

Information regarding your insurability will be treated as confidential. Trustmark Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit 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 of a request from you, the Bureau will arrange disclosure of any information it may have in your file. 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 procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Trustmark Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for insurance.

Detach and Deliver to Proposed Insured.

I573–NWB-321/R4-00

WHITE ORIGINAL (TOP) – Employer Copy • **YELLOW –** WES Copy • **WHITE CARD (BOTTOM) –** Employee Copy

Election Not To Participate

I have been given an opportunity to apply for insurance benefits as offered by my employer, and after careful consideration, I have elected not to take advantage of this offer.

I understand that, in the event I should decide to apply for insurance benefits hereafter, such subsequent application shall be subject to the applicable terms and conditions of the employer's insurance plan and the insurance company's underwriting rules.

Name of Employee: Date:

Signature of Employee:

Notice of Insurance Information Practices

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. As part of our normal procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry, if obtained, typically includes information as to your character, general reputation, personal characteristics and mode of living. You have a right of access and correction with respect to information collected about you. Address your request to receive additional information or a description of your rights to our Underwriting Department.

This Notification Must Be Detached and Delivered To Proposed Insured.