Underwritten by

Trustmark
LIFE INSURANCE COMPANY

TRUSTMARK LIFE INSURANCE COMPANY
Application for Insurance Coverage

Application is hereby made to Trustmark Life Insurance Company ("Company") for the insurance coverage(s) indicated below. This Application must be accepted and approved by the Company prior to any Contract being in effect.

Type of Coverage Applied for:

☐ Stop Loss ☐ Life and AD&D

Attach a copy of the proposal indicating the employer's plan selection(s) with this application.

Employer Information

FULL LEGAL NAME OF EMPLOYER		
KEY CONTACT AT EMPLOYER	COMPANY PLAN ADMINISTRATOR (NAME AND TITLE)	
ADDRESS (COMPANY HEADQUARTERS)	PHONE NUMBER	FAX NUMBER
CITY/STATE/ZIP CODE		E-MAIL ADDRESS
OTHER LOCATIONS. INCLUDE CITY, STATE AND ZIP CODE		
SUBSIDIARY OR AFFILIATED COMPANIES (COMPANIES UNDER COMMON CONTROL THROUGH STOCK OWNERSHIP, CONTRACT OR OTHERWISE) THAT ARE TO BE INCLUDED. LIST LEGAL NAMES AND ADDRESSES OF SUCH COMPANIES.		
NATURE OF EMPLOYER'S BUSINESS		
DATE BUSINESS STARTED	SIC CODE	

COMPANY DESCRIPTION

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other _____

Coverage Information

Proposed Effective Date: _____

Number of **full-time and part-time** employees: _____

Number of **full-time** employees: _____

Minimum number of hours worked per week to be an eligible employee (cannot be less than 25 hours per week) _____

Total eligible employees: _____

Number of employees covered under or in election period of COBRA or state continuation: _____

Number of employees in their **waiting period:** _____

NOTE: Any employees who are in their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Employee Eligibility Statement.

Employer Name: _____

Coverage Information (continued)

Waiting period for eligible employees: **CHOOSE ONE** of the following:

☐ Coverage begins on the first day of the month following _____ days of continuous employment, or

☐ Coverage begins immediately, following _____ days of continuous employment

The waiting period cannot exceed 90 days. If 60 or more days are chosen as the waiting period, coverage must begin immediately following the waiting period.

☐ Waive the waiting period for all employees during the initial enrollment

Carve Out? ☐ Yes ☐ No

If "yes," indicate the class to be covered _____

A. Aggregate Stop Loss ☐ Yes ☐ No

Benefit Period: Eligible Employer Losses from Plan expense

Incurred from_____through_____, and

Paid from_____through_____.

Losses incurred prior to the Effective Date will be limited to the amount as set forth in the Schedule of Stop Loss.

Coverages applying to Aggregate Stop Loss include (not included unless checked): ☐ Medical ☐ Prescription Drug Card Program

B. Specific Stop Loss ☐ Yes ☐ No

Benefit Period: Eligible Employer Losses from Plan expenses

Incurred from_____through_____, and

Paid from_____through_____.

Eligible expenses for Specific Stop Loss include: ☐ Medical ☐ Prescription Drug Card Program

Prior Coverage

Is prior group medical coverage? ☐ fully insured ☐ self-funded

Name of prior group medical carrier: _____In effect since: _____

Why are you leaving your current group carrier?_____

Premium renewal date with current group carrier? _____

Attach a copy of the most recent billing statement(s) from your prior carrier(s).

Contribution

Employer Contribution: Employer may contribute toward the health coverage.

Employer contribution for employees: _____% Employer contribution for dependents _____%

Billing

Premium bill type: ☐ Monthly Premium Statement ☐ Electronic funds Transfer (EFT) *Complete Authorization Form AD34*

"Bill to" Address (if different than Street Address of Company Headquarters).

If a "bill to" address is indicated below, the following items will be sent to the billing address:

- Billing statements
- Late payment reminders
- Nonpayment termination letters

The following items will not be sent to a "bill to" address, but will be sent to the address of the Company headquarters:

- Plan documents
- I.D. cards
- Renewal packets, and
- All other correspondence

Late payment reminders and nonpayment termination letters will be sent to both addresses.

Name _____

Billing Address _____

City _____ County _____ State _____ ZIP_____

Employer Name: _____

Risk Assumptions

Active Employees and Dependents:

The Company will rely on the data included in this Application to assist in underwriting the Employer for Insurance.

The Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form, which captures information regarding medical conditions and treatment of eligible persons, is made part of this Application for insurance and shall be relied upon in determining rates and eligibility for coverage.

The Company has the right to revise the rates (retroactively or prospectively) for the Stop Loss Insurance Contract, or rescind or terminate the Stop Loss Insurance Contract if a person completes the Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form (collectively "Form") with false, incomplete or misleading information or fails to notify the Company of any changes to the answers to the medical information question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.

General Conditions

It is understood and agreed as conditions precedent to the approval of this Application that:

- The Employer is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
- The Third Party Administrator retained by the Employer will be considered the Employer's Agent and not the Company's Agent;
- All documentation including the Employee Eligibility Statement requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within thirty (30) days of the Effective Date;
- The Company will evaluate the Employer's risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks;
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss.

In making this Application, all statements and descriptions are deemed to be representations and not warranties, and the Employer represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Employer to the proposed Contract. Accordingly, this request will be a part of the Contract if accepted by the Company.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at _____ this_____ day of _____ , 20 _____

Employer _____
Type or Print

Authorized Office/Partner _____ Title _____
Signature

Tax ID # _____ Witness: _____

Writing agent or broker of Employer _____
Please Print

Writing agent or broker of Employer _____
Signature

Address _____

_____

_____

Administered by Starmark®

Trustmark LIFE INSURANCE COMPANY

Broker Compensation Notice

Compensation will be paid according to the schedules defined in the most recent Broker Compensation Guide.

Primary Broker Name (Please print): _____

Social Security Number: _____ – _____ – _____

Complete this section only if Broker compensation is payable to an agency. Once an agency is designated as the entity to which compensation is payable, this designation can be changed only by obtaining a written release from the agency or upon receipt of a revised broker of record letter from the group.

Agency Name (Please print): _____

Federal Tax ID Number: _____ – _____

Complete this section only if compensation is payable to more than one broker or agency. NOTE: The total percentage of broker compensation listed below must be 100 percent.

BROKER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF BROKER COMPENSATION _____ %
BROKER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF BROKER COMPENSATION _____ %
BROKER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF BROKER COMPENSATION _____ %

I hereby certify that I, and any other agent or broker who will receive compensation, do hold any and all licenses required by law to solicit, sell and negotiate Life, Accident and Health insurance and to receive compensation. I have reviewed all enrollment and application materials and, to the best of my knowledge, all of the information is correct. I know nothing unfavorable about this employer or individual(s) applying for insurance. Furthermore, I certify that this employer is a bonafide business establishment and that participation and contribution requirements have been met. I understand that no compensation is payable until I am appointed by Trustmark Life Insurance Company, and that Trustmark Life Insurance Company will not pay me any compensation on costs attributed to periods of coverage prior to my appointment date.

I understand that I represent the interest of the applicant for insurance, not Trustmark Life Insurance Company, and have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is accepted. I understand that I have no right to bind this coverage, to alter terms of the insurance contract or application in any manner or to adjust any claim for benefits under the insurance contract.

Name of employer applying for insurance (please print): _____

Broker signature: _____ Date signed: _____

Compensation will only be paid for time periods in which you hold a valid license in the state this group is situs in.

BROKER COMPENSATION CANNOT BE PAID UNTIL THIS FORM IS COMPLETED AND RETURNED

Office Use Only

Group No. _____ **State** _____ **Eff Date** _____ **MGA** _____

No. of Medical Lives _____**and/or No. of Dental Lives**_____

HIPAA PLAN SPONSOR CERTIFICATION
FOR SELF FUNDED HEALTH PLAN SPONSORS

The Plan Sponsor must complete this form to certify that the group health plan documents have been amended to comply with HIPAA. No Protected Health Information (PHI) will be released until this form is complete.

If you sponsor a self-funded health plan, you must fill out this form.

By my signature below, the Plan Sponsor certifies that the governing documents for the group health plan (the "Plan") are amended to incorporate the following provisions, and that the Plan Sponsor shall:

a) not use or further disclose the PHI other than the minimum necessary information as permitted or required by the Plan or as required by law;

b) ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

c) not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor;

d) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures described in (a) above;

e) make available to the Plan PHI to comply with the HIPAA right to access in accordance with 45 CFR § 164.524;

f) make available to the Plan PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

g) make available to the Plan the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

h) make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy requirements;

i) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction of the information is not feasible, limit uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f) (2) (iii), is satisfied.

AUTHORIZED REPRESENTATIVES

You must provide a list of the individuals, including any agent, broker or agency who are authorized to have access to employees' PHI on behalf of the Plan for the purposes of Plan administrative functions. ONLY THOSE WRITTEN IN THIS BOX WILL BE AUTHORIZED. Please provide the first name, last name, title, and any agency name.

You are required to select the limit of PHI an Authorized Representative is allowed to receive. Authorized Representatives may have different access levels to employees' PHI as permitted by HIPAA. If there is a change to this list of Authorized Representatives, please contact us.

Name†	Title	PHI Access
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE

†If additional appointments for Authorized Representatives are needed and you run out of space on this form, please request the List of Authorized Representatives Form.

Access Levels

LMTD This individual works with enrollment, termination, COBRA, etc., and needs no additional health information.

CLMS 1 This individual needs to check the status of claims, and should have access to minimal PHI, including eligibility information.

CLMS 2 This individual assists participants in filing claims or appeals, and should have access to all claims data.

FINANCE This individual should receive reports related to the financial maintenance of the coverage (e.g., check registers).

PRIVACY OFFICIAL

You are required by HIPAA to name a Privacy Official. The Privacy Official is responsible for overseeing privacy compliance. The Privacy Official will be considered an Authorized Representative unless you specify otherwise.

If the Privacy Official changes, please contact us.

Privacy Official First and Last Name: _____

Title: _____

Contact Email: _____

Contact Phone: _____

PLAN SPONSOR NAME_____ GROUP ID NUMBER_____

Authorized Signature _____

Date:_____

Printed Name: _____

Title: _____

Starmark®
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

Sign Up for ACE/Electronic Billing

The following information should be completed by the administrator of a *new* group. (Existing groups should sign up through the Starmark® website.) If you want to signup for E-Bill both sections need to be completed.

- ACE user information

  Group name: _____

  Requester name: _____

  Requester phone: _____

  Requester e-mail: _____

- Receive e-mail billing statement. Please provide additional billing contact information only if other than requester named above.

  Billing contact name: _____

  Billing contact phone: _____

  Billing contact e-mail: _____

  The signature of an officer of the company is required if the requester listed above is not the administrator.

Signature _____ Date _____

400 Field Drive, Lake Forest, Il 60045-2581 • 847.615.1313 • 800.522.1246 • fax 847.615.3955