

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; it covers preventive care services only. Benefits are limited.** Your employer's self-funded 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 stop-loss insurance carrier 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 or terminate you or your dependent's coverage for fraud or intentional misrepresentation of material fact, 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER		BIRTH DATE (mm/dd/yyyy)	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> 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	Waiving Coverage
<p>Coverage applying for (Check only one):</p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee and Spouse/Domestic Partner*</p> <p><input type="checkbox"/> Employee and Child(ren)</p> <p><input type="checkbox"/> Employee, Spouse/Domestic Partner and Child(ren)</p> <p>Reason for enrollment (Check only one):</p> <p><input type="checkbox"/> New Group Plan</p> <p><input type="checkbox"/> New Hire</p> <p><input type="checkbox"/> Plan Change</p> <p><input type="checkbox"/> Open/Late Enrollment</p> <p><input type="checkbox"/> Special Enrollee (include Special Enrollee Form AD41)</p> <p>If no longer employed, but on COBRA or State Continuation, enter employment termination date (mm/dd/yyyy): _____</p> <p>* If your employer has designated eligibility for domestic partners, you may include a domestic partner as an eligible dependent.</p>	<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Self-funded medical coverage declined for:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Fully Insured Dental declined for (if available):</p> <p style="padding-left: 20px;"><input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren)</p> <p>I wish to decline for the following reasons (check one below):</p> <p><input type="checkbox"/> Covered by spouse/domestic partner's group health plan</p> <p><input type="checkbox"/> Government plan:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan</p> <p><input type="checkbox"/> Individual Medical Plan</p> <p><input type="checkbox"/> I do not have and do not want self-funded medical coverage</p> <p><input type="checkbox"/> COBRA/State Continuation**</p> <p><input type="checkbox"/> Other (explain): _____</p> <p>Employee Signature (if waiving coverage):</p> <p>Signature: _____ Date: _____</p> <p style="text-align: center;"> ORIGINAL SIGNATURE REQUIRED. PRINT THEN SIGN.</p> <p>** If you are declining coverage for any reason other than COBRA/State Continuation, please complete this section, sign above and return the application. If you are declining coverage due to COBRA/State Continuation, please complete the entire eligibility statement.</p>

OFFICE USE ONLY
UND _____ EFF _____ SUB _____

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 <input type="checkbox"/> M <input type="checkbox"/> F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> 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

Medical Information

Do not complete the medical information section below if applying for your employer's self-funded Preventive Care Plan.

Please answer yes or no to each item listed below:

1. Within the last 4 years, have you or any dependent applying for coverage received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following?

	Yes	No
A. Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
B. Arthritis (Rheumatoid Arthritis, Osteoarthritis, Psoriatic, other)	<input type="checkbox"/>	<input type="checkbox"/>
C. Autoimmune and/or connective tissue disorder, Lupus, Psoriasis or other Systemic disorder	<input type="checkbox"/>	<input type="checkbox"/>
D. Blood disorder (including Anemia and Hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>
E. Cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>
F. Congenital disorder	<input type="checkbox"/>	<input type="checkbox"/>
G. Digestive disorder (other than acid reflux): includes colon, intestinal, stomach, esophageal	<input type="checkbox"/>	<input type="checkbox"/>
H. Growth disorder or hormone disorder (other than thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
I. Heart or circulatory (other than high blood pressure or cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
J. HIV positive or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
K. Kidney, Liver or Pancreas	<input type="checkbox"/>	<input type="checkbox"/>
L. Muscle or joint disorders	<input type="checkbox"/>	<input type="checkbox"/>
M. Neurological (Multiple Sclerosis, Paralysis, Palsy, Seizures, Stroke, other)	<input type="checkbox"/>	<input type="checkbox"/>
N. Respiratory (other than allergies or asthma)	<input type="checkbox"/>	<input type="checkbox"/>
O. Reproductive disorder	<input type="checkbox"/>	<input type="checkbox"/>

2. **EMPLOYEE'S HEIGHT** _____ **WEIGHT** _____ **SPOUSE/DOMESTIC PARTNER'S (if applicable) HEIGHT** _____ **WEIGHT** _____

3. Have you or your spouse/domestic partner used any tobacco products in the past 12 months?

Employee: Yes No Spouse/Domestic Partner: Yes No Yes No

4. Have you or any dependent(s) applying for coverage been hospitalized, had surgery, or had more than \$5,000 in medical expenses in the last 12 months?

5. Have you or your dependent(s) applying for coverage been advised that hospitalization or surgery **will be necessary** in the next 12 months?

As part of the routine underwriting procedure, you may receive a telephone call from the stop-loss insurance carrier's home office to obtain additional information. Please provide detailed medical information on this form to reduce the need for a phone interview. Your answers will be strictly confidential.

Within the last 4 years, have you or any dependent applying for coverage received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions for the following?

6. Pregnancy	Yes	No
Are you or your dependent(s) included in this enrollment currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If no, proceed to question 7.		
If yes, name of person who is pregnant: _____ Due Date: _____		
Are multiple births expected? If yes, <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Quadruplets <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
Are there any known complications (i.e. eclampsia, gestational diabetes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify: _____		
Is a cesarean section anticipated?	<input type="checkbox"/>	<input type="checkbox"/>
7. Back/Neck	Yes	No
Have you or your dependent(s) received treatment or medication for a back/neck condition?	<input type="checkbox"/>	<input type="checkbox"/>
If no, proceed to question 8.		
If yes, name of person with the condition: _____		
Diagnosis (i.e. herniated disc, scoliosis, sprain, etc.): _____		
Date treatment started: _____ Date treatment ended: _____		
Treatment received: _____	<input type="checkbox"/>	<input type="checkbox"/>
Current medication(s): name, dose and frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>
Was this work related?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is a third party paying the claims?	<input type="checkbox"/>	<input type="checkbox"/>
Was this due to a Moving Vehicle Accident (MVA)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is a third party paying the claims?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has the case been settled?	<input type="checkbox"/>	<input type="checkbox"/>
Has future treatment or testing been recommended?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type of treatment or testing was recommended? _____		
Anticipated date(s) of treatment or testing: _____		
8. Diabetes or Pre-diabetes	Yes	No
Have you or your dependent(s) been diagnosed with diabetes or pre-diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
If no, proceed to question 9.		
If yes, name of person with the condition: _____		
Date diagnosed: _____		
Current medication(s): name, dose and frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an Insulin Pump already installed?	<input type="checkbox"/>	<input type="checkbox"/>
Is an Insulin Pump recommended?	<input type="checkbox"/>	<input type="checkbox"/>
Last blood sugar reading: _____ Date: _____		
Last A1C reading: _____ Date: _____		
Do you have a diabetic-related disorder (i.e. ulcers, kidney disorder, retinopathy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, details: _____		
Has future treatment or testing been recommended?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type of treatment or testing was recommended? _____		
Anticipated date(s) of treatment or testing: _____		
9. Mental/Nervous	Yes	No
Have you or your dependent(s) been diagnosed with a mental/nervous condition?	<input type="checkbox"/>	<input type="checkbox"/>
If no, proceed to next page.		
If yes, name of person with the condition: _____		
Diagnosis (i. e. depression, anxiety, bipolar, etc.) _____		
Date diagnosed: _____		
Current medication(s): name, dose and frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>
Treatment, dates, and frequency of outpatient counseling (if applicable): _____		
Have you been hospitalized for the condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date(s) hospitalized for treatment: _____		
Has suicide been attempted or threatened?	<input type="checkbox"/>	<input type="checkbox"/>
Date(s): _____		
Has future treatment or testing been recommended?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type of treatment or testing was recommended? _____		
Anticipated date(s) of treatment or testing: _____		

Medical Information (continued)

Please provide details for each YES answer on Page 2. If more space is needed, attach a separate sheet, sign and date it.

Question Number: _____

Person with the condition: _____ Exact diagnosis: _____

Date diagnosed: _____ Date last treated: _____

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking?	
			Yes	No
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

List all treatment received for this condition: _____

List all tests performed for this condition: _____

Results, readings and dates: _____

Any relapses or flare ups? Yes No Dates: _____

Have future tests, treatment, or surgeries been recommended? Yes No

If yes, what has been recommended? _____

Anticipated date(s): _____

Prognosis: _____

Question Number: _____

Person with the condition: _____ Exact diagnosis: _____

Date diagnosed: _____ Date last treated: _____

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking?	
			Yes	No
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

List all treatment received for this condition: _____

List all tests performed for this condition: _____

Results, readings and dates: _____

Any relapses or flare ups? Yes No Dates: _____

Have future tests, treatment, or surgeries been recommended? Yes No

If yes, what has been recommended? _____

Anticipated date(s): _____

Prognosis: _____

Question Number: _____

Person with the condition: _____ Exact diagnosis: _____

Date diagnosed: _____ Date last treated: _____

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking?	
			Yes	No
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

List all treatment received for this condition: _____

List all tests performed for this condition: _____

Results, readings and dates: _____

Any relapses or flare ups? Yes No Dates: _____

Have future tests, treatment, or surgeries been recommended? Yes No

If yes, what has been recommended? _____

Anticipated date(s): _____

Prognosis: _____

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 90 days from the date signed. I understand a person who knowingly and with intent to defraud files an application or statement of claim containing any false, incomplete or misleading information may be guilty of fraud which is a crime. I understand that if I, or any of my dependents, experience a change in health status after completing this form or before coverage becomes effective, it is my responsibility to notify Starmark underwriting immediately by sending an e-mail to STMUW@starmarkinc.com.

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, pharmacy or pharmacy benefit managers.

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, you authorize certain entities identified below to use or disclose your 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, you 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 your 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, pharmacy or pharmacy benefit managers 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 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 preventive care coverage plans:

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.

Go Green! Opt in to the Starmark® Document Center to:

- Access important health plan documents such as your Plan Document, and Summary of Benefits and Coverage online through your secure Starmark Account.
- Stop mail delivery and delays. The Document Center gives immediate access to important documents. You'll receive an email notification when a new document is available.
- Stop combing through paper documents. Your online documents are searchable using the PDF search feature.

Plus, opting in to the Document Center is easy. Simply check "yes, I agree" before signing the Employee Eligibility Statement, then opt in when you register at www.starmarkinc.com.