Starmark®
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Employee Medical Amendment

For my convenience, so that I am not required to complete an entire Employee Eligibility Statement for New Groups Enrolling **50 or Less** Employee Medical Lives (T401-17_50 or less), I understand that my answers in the Employee Medical Amendment and the Employee Eligibility Statement For New Groups Enrolling with **51 or More** Employee Medical Lives (T401-16_51+) will be relied upon to underwrite my employer's stop-loss insurance coverage and to set the contributions of my employer's self-funded plan. I understand that if I so choose, I may complete an Employee Eligibility Statement for New Groups Enrolling **50 or Less** Employee Medical Lives (T401-17_50 or less) in lieu of signing this Amendment.

I understand that the stop loss insurance company has the right to revise rates (retroactively or prospectively), rescind or terminate my Employer's Stop-Loss Insurance Contract if I completed these forms with false, incomplete or misleading information. The Plan or my Employer may rescind or terminate my or my dependent(s)'s coverage for fraud or intentional misrepresentation of material fact if I completed these forms with false, incomplete or misleading information. I understand that I have the opportunity to edit any of my information at this time by disclosing such information in the Employee Eligibility Statement.

I have read and agree to the attached Authorization.

Employee Signature_____ Date _____

Print Name _____

Group Name _____

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?

	Yes	No
1. Alcohol or Drug Use		
Have you or your dependent(s) used drugs not prescribed by a physician, been advised to have treatment or been treated for drug abuse, alcoholism, or been a member of Alcoholics Anonymous?	☐	☐
If no, proceed to question 2.		
If yes, name of person with the condition: _____		
List names of drugs/alcohol abused: _____		
Provide quantity (per day/week) of drugs/alcohol abused: _____		
Length of time used: _____		
Have you ever participated in a rehabilitation program and/or drug/chemical dependency program?	☐	☐
If yes, provide date of treatment:_____ Inpatient or Outpatient? _____		
Length/duration of the program: _____ Was the treament ordered?	☐	☐
Is there any current treatment?	☐	☐
If yes, provide frequency: _____		
Has there been any relapse?	☐	☐
If yes, provide date(s): _____		

	Yes	No
2. Back/Neck		
Have you or your dependent(s) received treatment or medication for a back/neck condition?	☐	☐
If no, proceed to question 3.		
If yes, name of person with the condition: _____		
Diagnosis (i.e. herniated disc, scoliosis, sprain, etc.): _____		
Date treatment started: _____ Date treatment ended: _____		
Treatment received: _____	☐	☐
Current medication(s): name, dose and frequency: _____	☐	☐
Was this work related?	☐	☐
If yes, is a third party paying the claims?	☐	☐
Was this due to a Moving Vehicle Accident (MVA)?	☐	☐
If yes, is a third party paying the claims?	☐	☐
If yes, has the case been settled?	☐	☐
Has future treatment or testing been recommended?	☐	☐
If yes, what type of treatment or testing was recommended? _____		
Anticipated date(s) of treatment or testing: _____		

	Yes	No
3. Diabetes or Pre-diabetes		
Have you or your dependent(s) been diagnosed with diabetes or pre-diabetes?	☐	☐
If no, proceed to question 4.		
If yes, name of person with the condition: _____		
Date diagnosed: _____		
Current medication(s): name, dose and frequency:	☐	☐
Do you have an Insulin Pump already installed?	☐	☐
Is an Insulin Pump recommended?	☐	☐
Last blood sugar reading: _____ Date: _____		
Last A1C reading: _____ Date: _____		
Do you have a diabetic-related disorder (i.e. ulcers, kidney disorder, retinopathy, etc.)?	☐	☐
If yes, details: _____		
Has future treatment or testing been recommended?	☐	☐
If yes, what type of treatment or testing was recommended? _____		
Anticipated date(s) of treatment or testing: _____		

PLEASE CONTINUE TO NEXT PAGE

4. Kidney Stones

	Yes	No
Have you or your dependent(s) been diagnosed with kidney stones?	☐	☐

If no, proceed question 5.

If yes, was this your first episode or recurrent?	☐	☐

If recurrent, please provide dates of all episodes: _____

b) How treated? ☐ Passed on own ☐ Surgical Removal ☐ Lithotripsy

c) List methods of treatment for asll, if more than one episode: _____

d) Are there any remaining kidney stones?	☐	☐

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5. Mental/Nervous

	Yes	No
Have you or your dependent(s) been diagnosed with a mental/nervous condition?	☐	☐

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:	☐	☐

Treatment, dates, and frequency of outpatient counseling (if applicable):

_____

_____

Have you been hospitalized for the condition?	☐	☐

If yes, date(s) hospitalized for treatment: _____

Has suicide been attempted or threatened?	☐	☐

Date(s): _____

Has future treatment or testing been recommended?	☐	☐

If yes, what type of treatment or testing was recommended? _____

Anticipated date(s) of treatment or testing: _____

Agreement to Enroll for Coverage

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, 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, 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.

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.