PLEASE CHECK APPROPRIATE BOXES:

Status:	**Active**	☐	**Annual Enrollment**	☐
	Retiree	☐	**New Enrollment**	☐
PLEASE PRINT	**COBRA**	☐	**Add Dependent**	☐
			Delete Dependent	☐
			Special Enrollment	☐

Applicant's Name (Last, First, MI):		Social Security Number:
Applicant's FULL Address: (Street)		
(City)	(State)	(Zip Code)
Telephone Number: ( )	School Name:	
Birthdate:	Marital Status: ☐ Single ☐ Married: Date _____ ☐ Divorced ☐ Widowed	
Sex: ☐ male ☐ female	Date of Employment:	Occupation:

Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months?	Self:	☐ Yes ☐ No
	Spouse:	☐ Yes ☐ No

Coverages Applying for:	Applicant	Spouse	Children
Medical: (Select One Plan)			
Plan C	☐	☐	☐
PPO 80	☐	☐	☐
PPO 90	☐	☐	☐
PPO HSA1	☐	☐	☐
PPO HSA2	☐	☐	☐
Retiree Coverage:			
– Under Age 65 (also select a plan above)	☐	☐	☐
– Age 65 and over (also select a plan below)	☐	☐	☐
Retiree Plan	☐	☐	☐
Retiree Plan with Deductible	☐	☐	☐

Refusal of Coverages:

	Applicant	Spouse	Children
Medical:	☐	☐	☐

I have been offered the above coverage and wish to decline enrollment for the following reason(s):

☐ Covered under Spouses insurance plan

☐ Other (please explain):

_____

_____

Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

CHRISTIAN SCHOOLS INTERNATIONAL

CSI INSURANCE PLAN AND TRUST FUND

GROUP ENROLLMENT FORM

All applicants selecting dependent coverage must complete dependent information.
If additional space is needed for dependents, attach a second form or a separate page.

1.	SPOUSE's Full Name: SSN:	Sex ☐ f ☐ m	Relationship: SPOUSE	Birthdate:	
2.	Dependent's Full Name: SSN:	Sex ☐ f ☐ m	Relationship: ☐ child/step child ☐ other _____	Birthdate:	Full Time Student ☐ yes ☐ no
3.	Dependent's Full Name: SSN:	Sex ☐ f ☐ m	Relationship: ☐ child/step child ☐ other _____	Birthdate:	Full Time Student ☐ yes ☐ no
4.	Dependent's Full Name: SSN:	Sex ☐ f ☐ m	Relationship: ☐ child/step child ☐ other _____	Birthdate:	Full Time Student ☐ yes ☐ no
5.	Dependent's Full Name: SSN:	Sex ☐ f ☐ m	Relationship: ☐ child/step child ☐ other _____	Birthdate:	Full Time Student ☐ yes ☐ no

I wish to apply for all coverages listed for which I am eligible under the group contract. I authorize payroll deductions for my share, if any, of the costs of the coverages applied for.

I understand that: in the event I desire at a later date, such coverages previously cancelled or refused, I will be required to furnish a late enrollee form and may be subject to an 18 month pre-existing condition exclusion.

_____ **APPLICANT'S SIGNATURE REQUIRED** _____ **DATE**

THIS CARD WILL NOT BE ACCEPTED UNLESS SIGNED AND DATED BY THE INSURED/APPLICANT.

PLEASE READ THE REVERSE SIDE FOR IMPORTANT INFORMATION REGARDING YOUR RIGHT TO SPECIAL ENROLLMENT AND PRE-EXISTING CONDITION LIMITATIONS.

TO BE COMPLETED BY GROUP ADMINISTRATOR:

Group #:	School #:	Region:	Division:	Class:	Effective Date:
GE997					

_____ Group Admin./Employer Signature _____ Date

Trustmark

LIFE INSURANCE COMPANY

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS AND PRE-EXISTING CONDITION LIMITATION

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 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Pre-existing Condition Limitation

This group health plan contains a pre-existing condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees) from the first day of coverage or of the waiting period, if any. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period which ends on the day before your coverage or the waiting period, if any, begins. This exclusion period may be reduced by the number of days of your prior creditable coverage. The plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certification(s) of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical healthcare program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, State Children's Health Insurance Program (S-CHIP), or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or HMO. If necessary, we will assist you in obtaining a certificate from any of these entities.

This Pre-existing Condition Limitation notice is being issued to you pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and reflects the protections afforded under federal law. If the state law applicable to your plan is more beneficial to covered individuals as to the length of the pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your plan.

You may contact us if you need additional information or assistance. All questions about preexisting condition exclusions and creditable coverage should be directed to Trustmark Life Insurance, Affinity Markets Division, 400 Field Drive, Lake Forest, IL 60045.