

ENTERED THROUGH ACE

# TRUSTMARK LIFE INSURANCE ENROLLMENT CARD

FOR TRUSTMARK USE  
Co. No. \_\_\_\_\_  
Wait \_\_\_\_\_  
Plan \_\_\_\_\_

PLEASE PRINT

UNDERWRITTEN BY TRUSTMARK LIFE INSURANCE COMPANY

NEW ENROLLMENT  PPO  HD  OPENACCESS  REINSTATEMENT  SPECIAL ENROLLMENT  CHANGE

<b>COMPANY NAME:</b>		
Employee's name (Last, First, MI):		Social Security Number:
Employee's Full Address: (Street)		Phone Number:
(City)	(State)	(Zip Code)
Birthdate: / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married Date: _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced Date: _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Full-Time Employment	Occupation:
<b>MEDICAL COVERAGE APPLIED FOR:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Children <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Family		
Coverage Change <input type="checkbox"/> Add <input type="checkbox"/> Spouse <input type="checkbox"/> Drop <input type="checkbox"/> Children <input type="checkbox"/> Family	<b>LIFE INSURANCE INFORMATION</b> Full name of Beneficiary  Relationship	
<b>REINSTATEMENT:</b> Date returned to work	Transfer From:	Date:
Spouse's name (Last, First, MI):		Spouse Birthday: / /
Spouse - Employer		Social Security Number:

NAMES OF ELIGIBLE DEPENDENT CHILDREN					FOR TMK USE	EFF. DATE
FIRST	MIDDLE	LAST	SEX	BIRTHDATE		
1.				/ /		
2.				/ /		
3.				/ /		
4.				/ /		
5.				/ /		

COMPLETE FOR FULL-TIME STUDENTS AGE 19-23		SOCIAL SECURITY NUMBER
NAME _____	SCHOOL _____	_____
NAME _____	SCHOOL _____	_____

FOR TRUSTMARK USE ONLY			
COVERAGE	PLAN	EFF. DATE	
LIFE			
MED			
A & H			
DENTAL			
DEP. LIFE			
TERMINATION DATE		HIPAA	

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.

### COMPLETE ONLY IF REFUSING GROUP INSURANCE

	Employee	Child(ren)	Spouse
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short term disability	<input type="checkbox"/>		

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

Covered under other insurance plan  
 Other (please explain) \_\_\_\_\_

N458-22/R3-06

Please read the reverse side for important information regarding your right to special enrollment and pre-existing condition limitations.

(TL)

\_\_\_\_\_  
Employee's Signature Date

To Be Completed By Group Administrator:

Group #	Group Name:
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\_\_\_\_\_  
Group Admin./Employer Signature Date

THIS CARD WILL NOT BE ACCEPTED BY TRUSTMARK UNLESS SIGNED AND DATED BY THE EMPLOYEE.  
Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

THE INFORMATION ON THIS FORM WILL REPLACE ANY PREVIOUSLY DATED FORMS THAT MAY BE ON FILE.



## **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.