Dental Employee Enrollment Form

_____PPO _____Indemnity

_____Employee Only_____Employee & Spouse _____Employee& Children _____Employee & Family

Administered by
Starmark
400 Field Drive • Lake Forest, IL 60045-2581

Fully insured by
Trustmark
LIFE INSURANCE COMPANY

EMPLOYEE ENROLLMENT FORM

To be completed by the EMPLOYEE ONLY
Print legibly in ink only

Note: If you make a mistake when completing an answer, please correct, initial and date.

NOTICE: A person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

❑ New Hire ❑ Late Enrollment ❑ Reinstatement ❑ Special Enrollee (include completed Special Enrollee Form (AD41))

EMPLOYER INFORMATION

Group Name _____ Location _____ (State ZIP) Group No. _____

Plan Choice. if available: Deductible _____ **Physician/Hospital Network** _____

EMPLOYEE INFORMATION - ALL FULL-TIME EMPLOYEES MUST COMPLETE THIS SECTION

Legal Name (First) _____ (M.I.) _____ (Last) _____

Address (Street) _____ (City) _____ (State) _____ (ZIP) _____

Sex	Social Security Number*	Birth Date	Marital Status
❑ Male ❑ Female			❑ Single ❑ Married

Work Phone (_____) _____ Home Phone (_____) _____ E-Mail _____

Date Employed Full Time _____ (mm/dd/yyyy) Job Title _____

Hours Worked Per Week _____ Annual Salary $_____

If no longer employed, but on **COBRA or State Continuation**, enter employment termination date _____ (mm/dd/yyyy)

Beneficiary Legal Name (First) _____ (M.I.) _____ (Last) _____ Relationship _____

LIST DEPENDENTS TO BE COVERED - If waiving dependents, must complete **WAIVER OF COVERAGE** section

***NOTE: Federal law (Medicare, Medicaid. and SCHIP Extension Act of 2007) requires Social Security numbers for all covered employees and their covered dependents.**

(First)	LEGAL NAME (Last)	BIRTH DATE	SOCIAL SECURITY NUMBER*	SEX M	SEX F
Spouse	Occupation			❑	❑
Child				❑	❑
Child				❑	❑
Child				❑	❑
Child				❑	❑

Note:
A dependent child is an unmarried child to age 25.

PROOF OF PRIOR COVERAGE

Complete this section only if you or your dependents are not covered under your employer's current group health plan. Did you or your dependent(s) have **MAJOR MEDICAL** coverage with another carrier(s) other than your current employer coverage within the past 12 months?

❑ Yes ❑ No

If yes, complete the following. (If insured with more than 1 carrier within the past 12 months, please attach certificate(s) of creditable coverage from prior plan(s)):

Employer Name _____ Phone (_____) _____

Prior Carrier Name _____ Phone (_____) _____

Policy No. _____ Effective Date _____ Termination Date _____

Covered Members (check all that apply) ❑ Employee ❑ Spouse ❑ Child(ren)

OFFICE USE ONLY

UND _____ **EFF** _____ **SUB** _____

WAIVER OF COVERAGE

This is to certify that I have been given the opportunity to apply for group medical, dental and/or any other coverage offered by my employer and that I have decided not to apply. **I understand that if I choose to apply for this coverage in the future, I or my dependents may be considered late enrollees and coverage may be delayed for up to 18 months.**

I also understand that if my employer offers any ancillary benefits (Employee Life, Employee Short Term Disability or Employee Long Term Disability), I will be covered under these benefits unless I decline all coverage offered by my employer or am not otherwise eligible for that coverage.

❑ Declining **all** group coverage offered by my employer at this time

❑ Medical coveraged declined for: ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Dental coverage, if available, declined for: ❑ Employee ❑ Spouse ❑ Child(ren)

Reason for declining coverage:

❑ Covered by Spouse's Group Health Plan
❑ Individual Medical Plan
❑ COBRA/State Continuation
❑ Not Affordable
❑ Other (explain)_____

❑ Government Plan
- ❑ Medicare
- ❑ Medicaid
- ❑ State Plan

AGREEMENT AND AUTHORIZATION

Unless waived above, I request insurance under my employer's insurance 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 application 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 in this application will be valid for 60 days from the date signed.

I authorize Trustmark, its authorized representative Star Marketing and Administration, Inc. (Starmark), its reinsurers and consumer reporting agencies, or any other authorized representatives, to obtain, use, and/or disclose certain information about me as indicated below.

Trustmark or Starmark may obtain and maintain Protected Health Information (PHI) about me to perform specific functions. This Authorization describes the type of information that is collected and my rights regarding how that information can be used.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- condition of my physical or mental health;
- health care provided to me; or
- payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

This information may be obtained from a number of sources including, but not limited to, applications for health plan coverage, questionnaires, health care providers, claims for payment filed by myself or health care providers, referrals made by health care providers, and my medical records. Other sources of PHI include group health plan administrators, insurance carriers, the Medical Information Bureau, employers, and other business partners such as pharmacy benefit managers, third-party administrators, consultants, agents or brokers. PHI may be obtained over the telephone, by mail, or e-mail.

PHI may be used by Trustmark or Starmark sales and underwriting personnel, legal, or others as may be necessary in order to provide insurance coverage. Additionally, PHI may be used by, and disclosed to other business partners, such as agents or brokers, for the purpose of determining eligibility for coverage.

Trustmark and Starmark are committed to the privacy of your PHI and have 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.

I understand I have a right to inspect and copy my own PHI to be used or disclosed. I also understand that failure to sign this Authorization will result in my application not being considered. I agree this Authorization will be valid until Trustmark or Starmark has completed its determination of my eligibility for coverage. A simulated, faxed or copied image of this Authorization shall be as valid as the original. I or my authorized representative may obtain a copy of this form upon request.

Employee Signature _____ **Date** _____