

PLEASE PRINT ALL INFORMATION — PLEASE SIGN AND DATE FORM ON PAGE 3
Note: If you make a mistake when completing an answer, please correct, initial and date.

NOTICE: Any 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.

Group Name _____

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

Covered by spouse's group health plan Medicare Other (please explain)

Individual Medical Plan Medicaid COBRA/State Continuation

If you are on COBRA coverage, please indicate date started and reason:

I am applying for coverage as a:

New Hire Special Enrollee Late Enrollee Reinstatement

Medical Plan Applying For: Group Select PPO Group Select HSA

Deductible Amount Selected (if more than one option offered): \$ _____

Physician/Hospital Network Selected (if more than one option offered): _____

	Employee		Spouse/Domestic Partner		Child(ren)	
	Applying	Waiving	Applying	Waiving	Applying	Waiving
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life/AD&D	<input type="checkbox"/>	<input type="checkbox"/>				
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>				
Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>				
Optional Life/Dependent Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employee Optional Life Amount: \$ _____

If applying for Life and/or Optional Life please indicate Beneficiary Designation:
Full Name: _____ Relationship: _____

If applying for Disability or Optional Life please indicate:
Base Annual Salary: \$ _____

If waiving coverage provide Employee Name, Social Security No. and Date of Birth below

Note: (Coverage can be waived only if you pay part or all of the premium.)

These questions apply to the Employee and any dependents who will be covered under your employer's benefits plan:

Employee Name: _____
First Middle Initial Last

Social Security No.: _____ Sex: M F E-mail address: _____

Address: _____ State: _____ Zip Code: _____ Home Phone #: _____

Date of Birth: _____ Height: _____ ft. _____ in. Weight: _____ lbs. Marital Status: Single Married

Date of Full-Time Employment: _____ Hours Worked Per Week: _____
mm/dd/yyyy

Occupation: _____ Hourly Salaried

Dependent Spouse/Domestic Partner Name: _____

Sex: M F Date of Birth: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Dependent Child(ren) Names:	Sex:	Birth Date:	Full-Time Student
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

TO BE COMPLETED BY GROUP ADMINISTRATOR

Group #:	Division #:	Class:	Dept. Location Code:	Effective Date:
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1. Have you or your Spouse/Domestic Partner smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months? Self Yes No Spouse/Domestic Partner Yes No

2. **Prescription Medication:** Please complete the grid below for the prescription medications you currently take daily or periodically as well as those currently taken daily or periodically by your dependents enrolling in your employer's benefits plan. It may be helpful to read the information from the medication's bottle or container in completing the grid.

Please check box if you or your dependent/s are not currently taking prescription medications.

Name / Relationship to Employee	Name of medication	Condition prescribed for	Dosage of the medication	How often is the medication taken?	Date you first began taking the prescription

3. **Medical Conditions:** Please indicate if you or any dependent to be covered under your employer's benefits plan has in the past 3 years been diagnosed with, or treated by, a member of the medical profession for the conditions listed below. If "Yes" is checked for any conditions, please complete the grid that follows the list with information pertaining to that diagnosis and treatment.

Condition	Yes	No
a. AIDS		
b. Alcohol or drug abuse treatment		
c. Blood disorder (including hemophilia and anemia)		
d. Bone/joint/muscle disorder (including arthritis, back/spine, physical deformity, or birth defect.)		
e. Cancer (including leukemia, Hodgkin's disease, melanoma and lymphoma)		
f. Diabetes, if yes, list last blood sugar or A1C reading here:		
g. Digestive/Intestinal disorder (including colon, Crohn's disease or ulcerative colitis)		
h. Endocrine, adrenal, or pituitary disorder		
i. Heart/circulatory disorder(s)/chest pain		
j. High blood pressure, if yes, list last 3 readings here:		
k. Immune deficiency disorder		
l. Kidney/liver/pancreas disease (including cirrhosis and hepatitis)		
m. Mental/nervous/behavioral disorder		
n. Neurological disorder (including cerebral palsy, multiple sclerosis, cystic fibrosis, stroke and paralysis)		
o. Reproductive/infertility/genitourinary disorder		
p. Respiratory/lung disorder (including but not limited to COPD and Emphysema)		
q. Tumor		
Additional questions on medical conditions:	Yes	No
r. Are you or any dependent to be covered under your employer's benefits plan currently pregnant? If yes, list due date in last column of the grid below. Please indicate details below if there are or have been in the past, complications, premature birth, multiple gestation or c-section.		
s. Have you or any dependent to be covered under your employer's benefits plan incurred more than \$10,000 in medical expenses in the past 12 months?		

If you answered "Yes" to any of the conditions or questions above, please provide additional information in the grid below.

Question Letter	Name / Relationship to Employee	Date of condition's onset	Date last seen by a physician for this condition	What is the recovery status?	Describe specific diagnosis for the noted condition. Also, if a medical procedure was performed or advised, indicate type of procedure

Please use back of page to record additional information as necessary.

AGREEMENTS

The answers and statements on this Enrollment and Medical Statement are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by Trustmark at its Home Office. I have read, or have had read to me, the completed Enrollment and Medical Statement and I realize that any false statements or misrepresentation in the Enrollment and Medical Statement may result in loss of coverage under the contract. The information on this form shall replace any previously dated forms that may be on file.

MEDICAL AUTHORIZATION

I authorize any of the following to disclose to Trustmark Life Insurance Company, Lake Forest, Illinois, any data it has on me or my health or on the health of my family: (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) the Medical Information Bureau; or (5) any other organization, institution or person that has data on me or my health or on the health of my family. I specifically authorize the release of information on alcohol or drug abuse and mental illness. I also authorize such disclosure of data to the reinsurer or Trustmark Life Insurance Company. I waive, to the extent allowed by law, all provisions of law forbidding such disclosure. I make such waiver on behalf of myself and any person who shall have or claim any interest on any insurance issued hereon. A copy of this shall be as valid as the original. This authorization is valid for 30 months.

When applying for multiple coverages through Trustmark under the same application or enrollment form (for example medical coverage with a life and/or disability income benefit), your personal information will be shared internally between those products for the purpose of administering all benefits. All information is held to the same privacy standards and is not used or disclosed unless required or permitted by law.

RISK ASSESSMENT

Any information on this Enrollment and Medical Statement form is attached to and considered a part of the Application, and will be relied on by Trustmark for purposes related to underwriting the coverage.

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

In compliance with Public Law 91-508, information regarding your insurability will be treated as confidential. Trustmark Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information on you it may have on file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, Massachusetts 02112, telephone number: (617) 426-3660.

Trustmark Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, 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 health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, State Children's Health Insurance Programs (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 Health Maintenance Organization (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 the 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 a part of your plan.

I wish to apply for all coverages as indicated above 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 an Enrollment and Medical Statement and may be subject to an 18-month pre-existing condition exclusion.

Signature of Employee

G490-5 3-05

Date

(TL) 3 GDRS R09-05