

PARTICIPATING EMPLOYER APPLICATION AND AGREEMENT

EMPLOYER INFORMATION

Employer _____ Phone No. _____
Full Legal Name of Company Fax No. _____

Street Address _____
Name and Street (No P.O. Boxes) City County State ZIP

Employer Tax ID Number _____ Date Business Started _____
mm/yyyy

Nature of Business _____ SIC Code _____

Company Description: Proprietorship Partnership Corporation Other _____

Correspondent _____ E-mail Address _____
Name and Title

LIST ANY OTHER LOCATIONS TO BE COVERED (i.e., Subsidiaries or Affiliates)

Common Ownership? Yes No

Name _____ Phone No. _____
Full legal name of company Fax No. _____

Street Address _____
Number and Street (No P.O. Boxes) City County State ZIP

Tax ID Number _____ Year Business Started _____

Nature of Business _____ SIC Code _____

Company Description: Proprietorship Partnership Corporation Other _____

If additional room is needed, attach separate sheets. Include all information required above. Must be signed and dated by company officer.

Desired effective date of insurance / / If other than the first day of month, please explain why _____
Mo. Day Yr.

IMPORTANT: Coverage is not effective without written notification from Trustmark Life Insurance Company or Star Marketing and Administration, Inc. Any existing coverage should remain inforce until such written notification is received.

Number of **full-time and part-time** employees _____ Number of full-time employees _____

Number of **employees eligible** for plan _____ Number of employees **covered under or in election period** of COBRA or state continuation _____

Carve-Out? Yes No If yes, class to be covered _____

Number of employees in their waiting period _____

NOTE: Employee Enrollment Forms must be submitted for all employees eligible within 60 days of the group's desired effective date.

Eligible employees will be insured the first day of the month following _____ days of continuous employment (waiting period)

Waive the waiting period for all employees during the initial enrollment.

EMPLOYER INFORMATION (cont.)

Bill to Address (if different than Employer Address above):

If this is chosen, the following items will be sent to the **physical address**: certificates and I.D. cards; renewal packets; late payment reminders; nonpayment termination letters; and all other correspondence. Items sent to the **billing address** are billing statements, late payment reminders, and nonpayment termination letters.

Name Mailing Address City County State ZIP

Bill to Address is: Bill Payment Office Accountant Other

Automated Customer Environment (ACE)

ACE Contact Name and Title E-mail Address

Select the desired option(s): Electronic Bill Electronic Funds Transfer (EFT) (Complete Authorization Form AD34)

Premium Billing Type: Monthly Premium Statement Electronic Funds Transfer (EFT) (Complete Authorization Form AD34)

Name of Previous Group Carrier: Medical Dental

Prior Coverage has been in effect since: Medical Dental

Why are you leaving your current group carrier?

Premium renewal date with your current group carrier?

ATTACH A COPY OF THE MOST RECENT BILLING FROM YOUR PREVIOUS PLAN(S)

- 1. Are there any employees who are not actively at work on the date of this application? YES NO
2. Are there any employees that have been absent from work 2 consecutive weeks in the past 12 months? YES NO
3. At any time during the past 24 months has your company had medical coverage terminated or a renewal of medical coverage refused? YES NO
4. During the last 12 months, has there been a 10% or more increase or decrease in the number of employees? YES NO
5. During the last 12 months, has your company's turnover rate for employees exceeded 30%? YES NO

If "yes" to questions 1-5, please explain

BILLING

Employers with 10 or more eligible employees - choose one billing methodology (assuming no change in demographic composition of the employer, both methods will result in the same premium).

- Individual Billing - each eligible employee is charged a rate that depends on the individual's demographic and family status.
Composite Billing - rating factors for all eligible employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

PARTICIPATION

Participation Requirements: Eligible employees and dependents may be able to waive medical and/or dental coverage and not be counted for participation requirements if they have comparable group coverage through their spouse and a minimum of 50% of all eligible employees have enrolled. ATTACH A COPY OF YOUR LAST QUARTERLY WAGE AND TAX STATEMENT.

Medical and all additional benefits: A minimum of 75% participation is required.
Employee Life, Dental or Employee Long Term Disability without medical: 100% participation is required.

CONTRIBUTION

Employer Contribution Requirements: Employer must contribute towards the overall cost of the group health plan. Minimum employer contribution is 25% of the total cost for employees and dependents or 50% of the total cost for employees.

Employee Contribution: %

Dependent Contribution: %

COMPREHENSIVE MEDICAL PLAN SELECTION

PPO Advantage Plan

Choose up to 2 Deductibles and only 1 of each of the others

- Calendar Year Deductible (In-Network/Out-of-Network)
 \$500/\$1,500 \$2,000/\$4,000
 \$1,000/\$2,000 \$3,000/\$6,000
 \$1,500/\$3,000

- Insured Percent (In-Network/Out-of-Network)
 90/70
 80/60

- Coinsurance Limit (In-Network/Out-of-Network)
 \$5,000/\$15,000
 \$10,000/\$20,000

Encounter Fee: \$20 \$30 \$40 No Encounter Fee

Physician/Hospital Network(s) - Select 1 network per business location up to a maximum of 5 networks:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Benefit Option (Only check if desired)

Maternity and Routine Nursery Care

Prescription Drug Card

\$10/\$25/\$40 or 30% Co-pay; \$400 Calendar Year Deductible; Included

- \$200 Calendar Year Deductible
 No Calendar Year Deductible

.....
 PPO Plan

Choose up to 2 Deductibles and only 1 of each of the others

- Calendar Year Deductible
 \$250 \$1,000 \$5,000
 \$500 \$1,500 \$10,000
 \$750 \$2,500

- Insured Percent (In-Network/Out-of-Network)
 90/80 80/70
 90/70 80/60
 90/60 70/60

- Coinsurance Limit
 \$5,000
 \$10,000
 \$15,000

Contract Option: Standard Enhanced

Office Visit Feature (available only with deductibles of \$250, \$500, \$750, \$1,000 and \$5,000)

- No Encounter Fee or Office visit Deductible
 In-Network Encounter Fee: \$15 \$20 \$25
 In-Network Encounter Fee/Out-Of-Network Office Visit Deductible: \$15/\$35 \$20/\$40 \$25/\$45

Physician/Hospital Network(s) - Select 1 network per business location up to a maximum of 5 networks:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Benefit Options (Only check options that are desired)

- Maternity and Routine Nursery Care
 \$500 Supplemental Accident
 Preventive Care Plus

Prescription Drug Card

\$10/\$25/\$40 or 30% Co-pay; \$400 Calendar Year Deductible; Included

- \$200 Calendar Year Deductible
 No Calendar Year Deductible

.....
 HRA Direct

- Calendar Year Deductible
 \$2,000 \$4,000
 \$3,000 \$5,000

- Insured Percent (In-Network/Out-of-Network)
100/70

- Coinsurance Limit
 \$5,000
 \$10,000
 \$15,000

Physician/Hospital Network(s) - Select 1 network per business location up to a maximum of 5 networks:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Benefit Options (Only check options that are desired)

- Maternity and Routine Nursery Care
 \$500 Supplemental Accident
 Preventive Care Plus

Prescription Drug Card

\$10/\$25/\$40 or 30% Co-pay; \$400 Calendar Year Deductible; Included

- \$200 Calendar Year Deductible
 No Calendar Year Deductible

Price Assurance Program

COMPREHENSIVE MEDICAL PLAN SELECTION (cont.)

HSA Select Plan

Choose up to 2 Deductibles and only 1 of each of the others

PPO

Calendar Year Deductible*
(In-Network/Out-of-Network)

- \$1,000/\$2,000
- \$1,500/\$3,000
- \$2,000/\$4,000
- \$3,000/\$6,000

Insured Percent
(In-Network/Out-of-Network)

- 100/80
- 90/70
- 80/60

Coinsurance Limit
(In-Network/Out-of-Network)

- \$5,000/\$10,000
- \$10,000/\$20,000

Physician/Hospital Network(s) - Select 1 network per business location up to a maximum of 5 networks:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Indemnity

Calendar Year Deductible*

- \$1,000
- \$1,500
- \$2,000
- \$3,000

Insured Percent

- 100
- 90
- 80

Coinsurance Limit

- \$5,000
- \$10,000

Benefit Options (Only check options that are desired)

- Maternity and Routine Nursery Care
- Preventive Care Plus

*NOTE: This amount will be adjusted each January 1st in accordance with the average percentage increase or decrease in the Consumer Price Index (CPI).

Qualified High Deductible Plan

Choose up to 2 Plans with the same Insured Percent

Plan
Physician/Hospital PPO

- A
- B
- C
- D
- E
- F

Individual/Family
Calendar Year Deductible*

- \$1,700/\$3,450
- \$1,700/\$3,450
- \$2,200/\$4,350
- \$2,200/\$4,350
- \$2,600/\$5,150
- \$2,600/\$5,150

Insured Percent
(In-Network/Out-of-Network)

- 100/80
- 90/70
- 100/80
- 90/70
- 100/80
- 90/70

Physician/Hospital Network(s) - Select 1 network per business location up to a maximum of 5 networks:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Indemnity

- G
- H
- I

Individual/Family
Calendar Year Deductible*

- \$1,700/\$3,450
- \$2,200/\$4,350
- \$2,600/\$5,150

Insured Percent

- 80
- 80
- 80

Benefit Option (Only check if desired)

- Maternity and Routine Nursery Care

*NOTE: This amount will be adjusted each January 1st in accordance with the average percentage increase or decrease in the Consumer Price Index (CPI).

Indemnity Plan

Choose up to 2 Deductibles and only 1 of each of the others

Calendar Year Deductible

- \$250 \$1,000 \$2,500
- \$500 \$1,500 \$5,000
- \$750

Insured Percent

- 80
- 70
- 60

Coinsurance Limit

- \$5,000
- \$10,000
- \$15,000

Benefit Options (Only check options that are desired)

- Maternity and Routine Nursery Care
- \$500 Supplemental Accident
- Preventive Care Plus

Prescription Drug Card

\$10/\$25/\$40 or 30% Co-pay; \$400 Calendar Year Deductible; Included

- \$200 Calendar Year Deductible
- No Calendar Year Deductible

ANCILLARY COVERAGE SELECTION

Employee Life Insurance and Accidental Death and Dismemberment Minimum benefit - \$15,000; Maximum benefit - \$250,000. Benefits for any class may not be more than 2½ times the benefit in the next lower class.

- Plan 1 - Flat amount: All employees \$ _____
- Plan 2 - Multiple of annual earnings rounded to next higher \$1,000
All Employees _____ times annual earnings
Maximum Benefit \$ _____
- Plan 3 - Specify the amounts for each class
Class 1 Partners, Officers, Proprietors \$ _____
Class 2 Managers, Department Heads \$ _____
Class 3 All Other Employees \$ _____

Dependent Life Insurance and Accidental Death and Dismemberment

- Spouse Under Age 65 \$5,000 Spouse Age 70 thru 74 \$2,500 Child Age 14 Days thru 6 months \$500
- Spouse Age 65 thru 69 \$3,250 Spouse Age 75+ \$1,750 Child Over Age 6 Months \$2,000

Dental

- | <u>Plan</u> | <u>Calendar Year Deductible</u> | <u>Insured Percent For Class 1 Services</u> | <u>Calendar Year Benefit Maximum</u> |
|--|---------------------------------|---|--|
| <input type="checkbox"/> INDEmnity A (5 insured employees minimum) | <input type="checkbox"/> \$50 | <input type="checkbox"/> 80 | <input type="checkbox"/> \$750 (IND B) |
| <input type="checkbox"/> INDEmnity B (2 insured employees minimum) | <input type="checkbox"/> \$100 | <input type="checkbox"/> 100 | <input type="checkbox"/> \$1,000 |
| | | | <input type="checkbox"/> \$1,250 |
| | | | <input type="checkbox"/> \$1,500 (IND A) |
- Optional Orthodontic Expense Benefit (IND A)

Employee Short Term Disability

| <u>Plan</u> | <u>Elimination Period</u> | <u>Maximum Duration</u> | <u>Percent of Salary</u> |
|----------------------------|---------------------------|-------------------------|-----------------------------|
| <input type="checkbox"/> 1 | 7 days | 26 weeks | <input type="checkbox"/> 50 |
| <input type="checkbox"/> 2 | 14 days | 52 weeks | <input type="checkbox"/> 55 |
| <input type="checkbox"/> 3 | 28 days | 130 weeks | <input type="checkbox"/> 60 |
| | | | <input type="checkbox"/> 66 |

Benefit Maximum \$ _____
(Write in desired amount: Minimum weekly benefit \$35; Maximum weekly benefit \$700; in \$50 increments.)

Optional Pregnancy Disability Benefit

Employee Long Term Disability - 2 insured employee minimum. Benefits are provided at 60% of basic monthly earnings with maximum benefit of \$5,000. Benefits over \$3,000 subject to financial underwriting. LTD Addendum (UW21) must be completed by employees with monthly salaries of \$5,000 or more.

| <u>Plan</u> | <u>Elimination Period</u> | <u>Maximum Duration*</u> | |
|----------------------------|---------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> 1 | 90 days | To age 65 | *Duration reduced after age 60 |
| <input type="checkbox"/> 2 | 180 days | To age 65 | |
| <input type="checkbox"/> 3 | 90 days | 5 years | |
| <input type="checkbox"/> 4 | 180 days | 5 years | |

Employee Life, Dental or Employee Long Term Disability Without Medical - 5 insured employees minimum. Complete corresponding section above.

GENERAL REPRESENTATIONS & AGREEMENTS

Eligible Employees: Employer certifies that it employs the number of full-time employees (30 hours or more per week) as noted previously on this form and that no part-time employees are to be included for coverage. The Employer agrees to make the benefit plans available to all present and future eligible employees, and understands that each employee must satisfy all eligibility requirements for his insurance to become effective.

Effective Date: Employer understands that **no insurance will become effective without written notification by** Trustmark Life Insurance Company (hereinafter Insurance Company), or its administrative representative Star Marketing and Administration, Inc. (hereinafter Starmark).

Medicare as Payor: Employer understands that medical benefits for employees or spouses who are age 65 and over will be paid secondary to Medicare when an employer has less than 20 employees. Covered charges will be reduced by any benefits payable by Medicare. When an employer has 20 or more employees medical benefits will be paid primary to Medicare. An employee may choose to voluntarily waive coverage under the medical plan and elect Medicare as sole payor.

Termination: Employer understands that he may cancel his insurance at any time by giving 30 days advance written notice to the Insurance Company or to Starmark. The Insurance Company may cancel the Employer's insurance only for stated reasons such as inadequate participation or contribution; non-payment of premium; or fraud.

Producer: Employer understands that the **Producer** submitting this application represents the Employer's interest, not that of the Insurance Company, and that the **Producer has no right to bind coverage, to alter terms of the Group Insurance Contract or Application in any manner, or to adjust any claim for benefits under the Group Insurance Contract.**

Subscription to Trust: Employer hereby applies for participation in The Starmark MET Group Insurance Trust and for enrollment in the Group Insurance Contract established thereunder.

Employer understands that: (a) as an employer he is establishing this plan and that neither Starmark, the Policyholder Trustees, nor the Insurance Company are acting as "sponsor" or "plan administrator," as defined in the Employee Retirement Income Security Act of 1974 (ERISA) as amended; and (b) any compliance under ERISA that is applicable to the sponsor or plan administrator will be fulfilled by the Employer, as its own legal counsel may determine. Employer understands that if it is subject to federal law which prohibits sex and age discrimination, it may have to choose pregnancy options or tailor their plans to comply, and/or state that legal counsel should be sought in this respect.

Employer agrees to be bound by the terms of the Group Insurance Contract and understands that any conflict will be resolved solely by reference to the Policy.

Employer agrees to promptly furnish Starmark, or Insurance Company, with records or other information required to ensure proper administration of the insurance plans of The Starmark MET Group Insurance Trust and associated trusts.

PLAN SPONSOR CERTIFICATION

During the term of this group health benefit plan you, the plan sponsor, may receive Protected Health Information. As set forth in the HIPAA Privacy Rule (Rule), Protected Health Information (PHI) includes individually identifiable health information and relates to the past, present, or future:

- condition of an individual's physical or mental health;
- health care provided to an individual; or
- payment for health care provided to an individual.

As plan sponsor of a fully insured group health plan, you may choose not to receive PHI from us. If you make this selection below, your group health plan will be exempt from the administrative requirements of the HIPAA Privacy Rule. Whether or not you receive PHI from us, you, the plan sponsor, must agree to safeguard and protect the confidentiality of any PHI you receive and to sign this Certification. The plan sponsor also agrees to amend the plan document of the group health plan consistent with this Certification.

EXEMPTION FROM ADMINISTRATIVE REQUIREMENTS

The group health plan may be exempt from the administrative requirements of the Rule if it does not create or receive PHI on plan participants, except for:

- a. summary health information (health information that does not identify the individual to whom it applies); or
- b. information on enrollment or dis-enrollment from the insurance health plan.

Administrative requirements include: assignment of privacy officer and contact person, employee training; safeguard protections for PHI; handling privacy complaints; sanctions for non-compliance with privacy policies and procedures; mitigation for harmful effects of use and disclosure in violation of privacy policies and procedures; developing privacy policies and procedures; creating Privacy Notice.

PLAN SPONSOR CERTIFICATION

I, the plan sponsor, or the designated representative of the plan sponsor, certify that the plan sponsor will:

- Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the plan sponsor.
• Not use or disclose to anyone the PHI of any individual covered under this group health benefit plan other than as described in this Certification, and permitted or required by the HIPAA Privacy Rule and other applicable law.
• Ensure that any agents, including subcontractors, to whom I provide PHI, agree to the same restrictions and conditions that apply to the plan sponsor in connection with the HIPAA Privacy Rule.
• Report to the group health benefit plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the HIPAA Privacy Rule and other applicable law.
• Make available PHI as required in the Rule for Access of Individuals to their own PHI.
• Make available PHI as required in the Rule in order to amend PHI and incorporate any amendment to PHI in accordance with the Rule.
• Make available the information required to provide an accounting of disclosures of PHI as required by the Rule.
• Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health benefit plan available to the Secretary of the Department of Health and Human Services.
• Return or destroy, if feasible, all PHI received from the group health benefit plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made.
• Provide a List of Authorized Representatives which includes the identity or job title and affiliation of persons required or permitted to receive information in order to perform services on behalf of the group health benefit plan.
• Provide PHI only to those individuals or entities identified on the List of Authorized Representatives.
• Provide an effective mechanism for resolving any issues of noncompliance with the provision of this Certification.

Please indicate your choice:

- _____ No, I do not want to receive protected health information and understand that I am exempt from the administrative requirements of the Rule.
_____ Yes, I want to receive detailed protected health information and I will comply with the administrative requirements of the Rule.

LIST OF AUTHORIZED REPRESENTATIVES

List any individual other than the correspondent who will perform administrative functions for your group health plan and may have access to Protected Health Information (PHI) or summary health information. These individuals are authorized to discuss PHI that is the minimum necessary to administer the group health plan.

Name and/or Title of Person: _____

Company Name: _____

How does the Authorized Person use or disclose PHI in the performance of their job duties?

(If more space is needed, please use another sheet of paper.)

If there are any changes to be made to this list, additions or deletions, the plan sponsor is required to notify us within 30 days of the change.

SIGNATURE

I hereby represent that all the information herein, relative to this application and agreement, is true and complete and that I have read and understand the form. I understand that the Insurance Company will rely on these statements and this information in approving this application and in determining if the enrolling employees may become insured.

(Please print)
Company Officer _____ Producer _____
Signature of Producer

Title _____ Managing General Agent _____

Company Officer Signature _____ Date Signed _____



COMMISSION NOTICE

PRODUCER NAME _____
PLEASE PRINT

SOCIAL SECURITY NUMBER _____ - _____ - _____

COMMISSIONS WILL BE PAID ACCORDING TO THE TERMS OF THE MOST RECENT MGA CONTRACT OR COMMISSION SCHEDULE ON FILE.

COMPLETE THIS SECTION IF COMMISSIONS ARE PAYABLE TO AN AGENCY.

AGENCY NAME _____
PLEASE PRINT

FEDERAL TAX ID NUMBER _____

COMPLETE THIS SECTION IF THERE IS MORE THAN ONE PRODUCER.

1) PRODUCER OR AGENCY NAME _____

SOCIAL SECURITY OR FEDERAL TAX ID NUMBER _____

COMMISSIONS PAYABLE _____ %

2) PRODUCER OR AGENCY NAME _____

SOCIAL SECURITY OR FEDERAL TAX ID NUMBER _____

COMMISSIONS PAYABLE _____ %

I hereby certify that I and any other agent or producer who will receive commissions do hold valid Life, Accident and Health Licenses issued by the state in which this document was executed. I have reviewed all enrollment and application materials and to the best of my knowledge all of the information is correct, and I know nothing unfavorable about this Firm or individual(s) applying for insurance. Furthermore, I certify that this Firm is a bonafide business establishment and that participation and contribution requirements have been met. Eligibility provisions and pre-existing condition limitations have been fully explained to and understood by the employer identified in this document.

I understand that I represent the interest of the applicant for insurance, not Trustmark Life Insurance Company, and have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is accepted. I understand that I have no right to bind this coverage, to alter terms of the Insurance Contract or application in any manner or to adjust any claim for benefits under the Insurance Contract.

Name of Employer Applying for Insurance

Producer Signature

Date

OFFICE USE ONLY

Group No. _____ **State** _____ **MGA** _____ **No. of Lives** _____