Trustmark
benefits beyond benefits

Employee Eligibility Statement
for New Enrollees of Existing Groups

Small Business Benefits

Coverage Applied For (Check only one): ☐ Major Medical Plan ☐ Preventive Care Plan (non-major medical)*

*** IMPORTANT NOTICE: This plan does not provide comprehensive major medical coverage; it covers preventive care services only. Benefits are limited.** Your employer's self-funded preventive care benefit plan currently fulfills an individual's requirement under the Affordable Care Act to maintain minimum essential coverage, subject to revision of applicable law, regulation and regulatory interpretation.

To be completed by the **EMPLOYEE ONLY.** Print legibly in ink only. If you make a mistake when completing an answer, please correct, initial and date.
NOTICE: The stop-loss insurance carrier has the right to revise rates (retroactively or prospectively), rescind or terminate your employer's Stop Loss Insurance Contract if you complete this form with false, incomplete or misleading information. Your employer may rescind or terminate you or your dependent's coverage for fraud or intentional misrepresentation of material fact, if you complete this form with false, incomplete or misleading information. Plans are administered by Star Marketing and Administration, Inc.

Employer Information

COMPANY NAME	LOCATION (State, ZIP)	
Coliseum Companies, Inc. DBA Bay State Linen	Brockton, MA 02301	
PLAN CHOICE (if available): DEDUCTIBLE	**PHYSICIAN/HOSPITAL NETWORK**	**GROUP Number (If available)** SM91221E

Employee Information (All full-time employees must complete this section.)

LEGAL FIRST NAME	MIDDLE INITIAL	LEGAL LAST NAME	
ADDRESS	CITY	STATE	ZIP
SEX ☐ Male ☐ Female	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yyyy)	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced*
WORK PHONE	HOME PHONE	MOBILE PHONE	EMPLOYEE E-MAIL ADDRESS
DATE EMPLOYED FULL TIME (mm/dd/yyyy)	JOB TITLE	HOURS WORKED PER WEEK	ANNUAL SALARY $

Beneficiary Information - (Complete when employer is offering Life/Accidental Death & Dismemberment coverage)

BENEFICIARY NAME: First	M.I.	Last	Relationship	
NA				
ADDRESS:	City		State	ZIP

Coverage Information - Please check in appropriate boxes

Applying for Coverage

Coverage applying for (Check only one):

- ☐ Employee only
- ☐ Employee and Spouse/Domestic Partner**
- ☐ Employee and Child(ren)
- ☐ Employee, Spouse/Domestic Partner and Child(ren)

Reason for enrollment (Check only one):

- ☐ New Group Plan
- ☐ New Hire
- ☐ Plan Change
- ☐ Open/Late Enrollment
- ☐ Special Enrollee

*** If divorced and covering ex-spouse on COBRA, advise date divorce was finalized** (mm/dd/yyyy): _____

**** If the employer has designated eligibility for domestic partners, you may include a domestic partner as an eligible dependent.**

Waiving Coverage

☐ Declining **all** group coverage. I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

☐ Self-funded medical coverage declined for:
☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ Fully Insured Dental declined for (if available):
☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

I wish to decline for the following reasons (check one below):

- ☐ Covered by spouse/domestic partner's group health plan
- ☐ Government plan:
  - ☐ Medicare ☐ Medicaid ☐ State plan
- ☐ Individual Medical Plan
- ☐ I do not have and do not want self-funded medical coverage
- ☐ **COBRA**
- ☐ Other (explain): _____

Employee Signature (if waiving coverage):

Signature: _____ **Date:** _____

✍ **FIRST AND LAST NAME**

OFFICE USE ONLY

UND_____ EFF _____ SUB _____

Special Enrollee

If you are an employee or dependent(s) who previously waived coverage and now have **lost coverage, had a contribution change or a life-changing event, you may be considered a Special Enrollee. Star Marketing and Administration, Inc. must receive these forms within 31 days of the special enrollment event.** Failure to submit your request within the 31 days could result in a delay in coverage.

Name of person(s) applying for coverage, if OTHER than the employee: ______________________________

Unless otherwise noted, you must provide supporting documentation within the 31 days of your special enrollment event. If you are unable to obtain the supporting documentation within the time frame allotted, please do not delay your enrollment request. We will hold your request until the necessary information is received. Once approved, you will be added to the plan as of your event date and premium will be charged accordingly.

☐ **Loss of Coverage (including occurrences due to entrance into the U.S.):** Coverage Termination Date: ____________ **MM/DD/YY**

Type of Loss: ☐ Group Coverage ☐ Individual Coverage

Reason for Loss: ☐ Job termination ☐ No longer eligible – company policy (i.e., dependent coverage is no longer offered, etc.)

☐ Other ______________________________

☐ **Contribution Change:** Date of Change: ____________ **MM/DD/YY**

☐ Contribution (increase/decrease in employer contribution level)

☐ **Life-Changing Events:**

- ☐ Adoption of a child – Date of Placement: ____________
- ☐ Divorce – Date: ____________
- ☐ Marriage – Date: ____________ *Documentation is not required.*
- ☐ Birth of a child
- ☐ Legal separation

☐ **Other**: Provide Detailed Explanation:

____

____

Dependent Information

List the dependents to be covered. NOTE: If you are waiving coverage for your dependents, please complete the **Coverage Information** section on the first page.

SPOUSE/DOMESTIC PARTNER LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐M ☐F

Other Coverage

Do you or any dependent(s) enrolling on this form have existing major medical coverage that will be in effect on the day this coverage begins?

☐ Yes ☐ No If Yes, complete this section:

Name of Other Carrier: ______________________________ Start Date ____________

If Medicare check type of coverage:

☐ Part A Effective date:__________ ☐ Part B Effective date:_________ ☐ Part C Effective Date:_________ ☐ Part D Effective date: _________

Who is covered? ☐ Employee ☐ Spouse/Domestic Partner ☐ Children

SIGNATURE AND DATE ARE REQUIRED ON THE AGREEMENT AND AUTHORIZATION SECTION. CONTINUED ON THE NEXT PAGE.

Agreement to Enroll for Coverage

Unless waived on Page 1, I request coverage under my employer's 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 Employee Eligibility Statement 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 will be valid for 90 days from the date signed. I understand a person who knowingly and with intent to defraud files an application or statement of claim containing any false, incomplete or misleading information may be guilty of fraud which is a crime. I understand that if I, or any of my dependents, experience a change in health status after completing this form or before coverage becomes effective, it is my responsibility to notify Star Marketing and Administration, Inc. underwriting immediately by sending an e-mail to MedUnderwritingSB@trustmarkbenefits.com

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

Star Marketing and Administration, Inc. is committed to the privacy of your PHI/Personal Information and has 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, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be Protected Health Information and/or Personal Information. Protected Health Information (PHI) includes individually identifiable health information that is created or received by your provider, health plan or insurer, data clearinghouse, a health authority, employer, school or university, pharmacy or pharmacy benefit managers.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare provided to you. PHI/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability Act Privacy Rule.

By signing this form, you authorize certain entities identified below to use or disclose your protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

II. Purpose of the Authorization Form

By signing this form, you authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for your employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

I hereby authorize the following entities, their reinsurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above:

Star Marketing and Administration, Inc.
Trustmark Life Insurance Company

I authorize Entities to disclose my PHI between themselves and their affiliated companies, to reinsuring companies, to the plan administrator or plan sponsor.

I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, pharmacy or pharmacy benefit managers or other medical or medically related facility, insurance or reinsuring company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including, but not limited to, all medical and healthcare records.

I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed.

I understand that failure to sign this Authorization will result in my application not being considered.

I understand that my Personal Representative or I have a right to receive a copy of the authorization form.

A simulated, faxed or copied image of this Authorization shall be as valid as the original.

IV. Term of Authorization

I further agree this Authorization will be valid until Star Marketing and Administration, Inc. has completed its determination of my eligibility for coverage or for 12 months from the date signed, whichever is less.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to the entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I AGREE THAT A FAXED OR COPIED IMAGE OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

VI. Employee Consent for Electronic Distribution of Documents and Notices

As an employee enrolled in your employer's plan, you are entitled to receive plan documents and notices describing your rights, obligations, and benefits under your employer's plan. It is important that you receive these materials and become familiar with the information they contain. In an effort to reduce paper consumption and deliver this information to you faster, you may elect to receive employee benefit plan documents and notices related to your employer's plan electronically. Please be advised that you are not required to provide consent to receive these materials electronically, and if you elect not to provide consent, these materials will be sent to you by regular postal mail.

Agreement to Enroll for Coverage

By choosing to go paperless, you'll receive email notifications when new materials related to your rights, obligations, and benefits under your employer's plan have been posted. You will then have to login to your account via Trustmark's Small Business Benefits' secure portal to view the documents. By providing consent, you agree to receive employee benefit plan documents and notices electronically, including, but not limited to the following:

- Explanation of Benefits (EOB)
- Plan Document
- Summary Plan Description (and Summaries of Material Modifications)
- Policies and Certificates of Coverage
- Legally required notices, such as HIPAA Notice of Privacy

You may withdraw this consent to receive electronic distribution as described herein at any time by logging into your account at TrustmarkSB.com/login.

You also have the right at any time to request and obtain a paper version of any document, free of charge, that is provided to you electronically by contacting Trustmark at AdministrationSB@trustmarkbenefits.com.

BY SIGNING THIS DOCUMENT AND CHECKING THE BOX BELOW, I AGREE AND CONSENT TO RECEIVE PLAN DOCUMENTS AND NOTICES DESCRIBING MY RIGHTS, OBLIGATIONS, AND BENEFITS UNDER MY EMPLOYER'S PLAN ELECTRONICALLY AS DESCRIBED HEREIN. I UNDERSTAND THAT THIS CONSENT IS VOLUNTARY AND I CAN WITHDRAW MY CONSENT AT ANY TIME. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE MY INFORMATION IF THERE ARE ANY CHANGES THAT WOULD PREVENT ME FROM RECEIVING PLAN MATERIALS ELECTRONICALLY.

☐ **I AGREE TO RECEIVE DOCUMENTS ELECTRONICALLY AT THE EMAIL ADDRESS LISTED ON PAGE 1.**

Electronic Signature and Transmission. Signature pages of this Employee Eligibility Statement may be executed via a hand-written signature or electronic signature. The executed signature pages may be delivered using pdf or similar file type transmitted via electronic mail, cloud-based server, e-signature technology or other similar electronic means. The Employee agrees that its electronic signature will be enforceable as and to the full extent of a hand- written signature as an original for enforcement/enforceability of this form. The Employee agrees that it will not raise any defenses or invoke regulatory or statutory claim attempting to invalidate the enforceability of this Application if an electronic signature is affixed.

EMPLOYEE SIGNATURE: _____ DATE _____

OFFICE USE ONLY: UND_____ EFF_____ SUB_____

Important Notice: Please Read and Retain

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 health benefit plan, provided that you request enrollment within 31 days after coverage was terminated as a result of loss of eligibility for the coverage or termination of employer contribution (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). In addition, if you have a life-changing event, such as marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrol lment period, which is the month prior to the start of the new plan year.

ID Cards

ID cards are generally received 7 to 10 business days following enrollment and the activation of the employer-sponsored health benefit plan. For added convenience, if a need arises prior to receiving the ID card, covered employees can access a duplicate version of the ID card electronically after registering at **TrustmarkSB.com/login.** The digital ID card can be saved locally to a mobile phone or tablet (as a photo image or to the Wallet); printed, and/or uploaded to the provider's portal in advance of any appointment.

Access to Electronic Plan Documents and EOBs

By choosing to go paperless, you'll receive email notifications when important plan documents and an Explanation of Benefits (EOB) become available through our secure portal, **TrustmarkSB.com/login.**

- Reducing paper consumption is a simple way to have a huge impact on the environment.
- It's easier to search digital plan documents. No need to store paper files.
- You decide when to view, save or print your plan documents or EOBs.
- Documents available round the clock at your convenience. Don't wait for the USPS.

To eliminate receiving paper documents, **register at TrustmarkSB.com/login** and select "I agree" for both paperless plan documents and EOBs.

The following notice applies to benefit plans that ONLY have preventive care coverage:

Preventive care only benefit plans do not provide comprehensive major medical coverage. Benefits are limited. Preventive care only benefit plans fulfill an individual's requirement under the Affordable Care Act to maintain minimum essential coverage, subject to revision of applicable law, regulation and regulatory interpretation.