EXPRESS CONNECT ENROLLMENT GUIDE FOR EMPLOYEES
Express Connect streamlines your health plan enrollment process. You simply call a toll-free number to enroll. It’s that easy.

What You Need to Do

1. **Acknowledge agreements.** To proceed with Express Connect, you will be asked if you have read and understand the agreements and notices on pages 3 and 4 of this guide.

2. **Gather information before the call,** including information about you, your spouse and dependent(s).

3. **Make the call.** Call Starmark at a time convenient for you to enroll or waive coverage. At the conclusion of the call, all employees, including those who are waiving coverage, will be asked to acknowledge that they are signing the enrollment form electronically, and will be asked to answer a few questions to complete the process.

What You Can Expect

- **Knowledgeable and friendly staff.** A client service representative will answer your call during the scheduled enrollment times provided by your employer.

- **Call duration.** Express Connect enrollments typically take between 10 and 15 minutes to complete. It may take longer when multiple dependents apply for coverage or for lengthy medical histories.

- **Protecting your privacy.** Starmark understands the importance of protecting your privacy, and fully complies with the privacy protections of the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations. To view Starmark’s Privacy Notice and complete privacy policy, visit the Privacy section of the website at www.starmarkinc.com.

- **Completing the process.** Once your employer accepts the Starmark offer, a copy of your Employee Eligibility Statement will be mailed directly to your home address.

Phone Number:

Phone Line Hours:

Scheduled Call Dates:
Information Needed for the Call

There are two main categories of information collected during the enrollment process: enrollment and medical information. To ensure your phone enrollment process goes smoothly, please have the following information available prior to calling Starmark.

**Enrollment Information**
- Your employer’s name and location
- If you are waiving coverage, you will be asked to provide the reason.
- If you are currently covered through COBRA or state continuation, you will be asked:
  - The termination date of employment: ______________________________________________
  - Reason COBRA or state continuation was offered: ________________________________
- The following employee, dependent spouse and dependent children information is required:
  - Employee demographics: name, address, Social Security number, birth date, marital status, home and work phone, e-mail address, date employed full time, job title, hours worked per week and annual salary.
  - Spouse and dependent demographics: spouse name, occupation and birth date; dependent name(s) and birth date(s).
  - The effective and termination dates for prior coverage within the last 12 months.

**Medical Information**
Please make sure the following information is available for each person, including dependents, applying for coverage. Use this worksheet to help you prepare for your enrollment call.
- Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form in the last 12 months?
  - Self: ☐ Yes ☐ No
  - Spouse: ☐ Yes ☐ No
- Current prescription drug usage, including name of drug, condition prescribed for and dosage. Having the prescription bottles on hand will be helpful, or you may wish to complete the grid below prior to your call.

<table>
<thead>
<tr>
<th>Name/Relationship to Employee</th>
<th>Drug Name</th>
<th>Prescribed for Which Condition</th>
<th>Drug Dosage</th>
<th>Frequency Taken</th>
<th>Date First Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- You will be asked the height and weight of you and your spouse.
- You will be asked if you or any dependent has been diagnosed, treated, tested, or advised treatment or drugs for the conditions listed below in the past four years:
  - ☐ Alcohol abuse or alcoholism, or drug abuse
  - ☐ Arthritis
  - ☐ Back
  - ☐ Colon
  - ☐ Diabetes
  - ☐ Heart or circulatory (other than high blood pressure)
  - ☐ HIV or AIDS
  - ☐ Immune deficiency disorder
  - ☐ Intestinal
  - ☐ Kidney
  - ☐ Liver
  - ☐ Mental or emotional
  - ☐ Muscular
  - ☐ Neurological
  - ☐ Reproductive organs
  - ☐ Respiratory
  - ☐ Seizures
  - ☐ Stroke
  - ☐ Systemic
  - ☐ Tumor/cancer
- You will be asked if you or any dependent has been hospitalized, had surgery, had more than $5,000 in medical expenses in the last 12 months or has been advised that hospitalization or surgery is necessary.
- You will be asked if you or any dependent is pregnant and the subsequent due date.
Medical Information (continued)
You may also be asked to answer the following questions:

• Within the last four years, have you or any dependent received or been scheduled to have treatment and/or drug(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following:
  - Allergy
  - Asthma
  - Breast
  - Digestive system
  - Ear
  - Eye
  - Headache
  - Hernia
  - High blood pressure
  - Prostate
  - Rectal
  - Thyroid
  - Ulcer
  - Urinary tract

• Within the last four years, have you or any dependent received or been scheduled to have treatment and/or drug(s), or been advised to receive treatment for any reason not already mentioned?  □ Yes  □ No

If you answer “Yes” to any of the conditions or questions above, you will be asked to provide additional information. The additional information requested would follow the format below, which you may wish to complete prior to your call:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Person Treated</th>
<th>Nature of Condition; And/or Diagnosis</th>
<th>Duration Dates: From To</th>
<th>Explain Treatment: Include Date of Disability, Hospitalization, Medication (include dosage), Tests and Surgery</th>
<th>Results/Degree of Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notices and Agreements
During your call, you will be asked to verify that you read and understood the following agreements and notices.

Medical Authorization
Unless waived, I request coverage under my employer’s health 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 enrollment or any medical questionnaires are complete and true, and I understand that answers will be the basis of any plan issued. I also understand that all statements and answers made in this enrollment will be valid for 60 days. I understand 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.

I authorize Trustmark Life Insurance Company (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 necessary.

Risk Assessment
Any information on this enrollment and medical statement form is attached to and considered a part of the enrollment, and will be relied on by Trustmark and Starmark for purposes related to underwriting coverage.

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 certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy including a short term plan, Medicare, Medicaid, CHAMPUS, Federal Employees Health Benefit Plan (FEHBP), a medical healthcare program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan,
Pre-existing Condition Limitation (cont.)

governmental plans, church plan or a health plan issued under the Peace Corps Act, Social Security, or State Children’s Health Insurance Program. 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 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.

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided you request enrollment within 31 days after the involuntary loss of other coverage. Plus, if your current coverage changes or you have a life-changing event, such as a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

Late Enrollees

If you waive coverage at the original effective date of your employer’s plan and do not qualify as a special enrollee, coverage will start as follows:

- If your employer’s plan has been in force for less than 12 months, coverage will start on the plan’s first anniversary.
- If your employer’s plan has been in force for 12 months or more, coverage will start on the first day of the month following the date the Employee Eligibility Statement is signed.

If you are hired after the original effective date of your employer’s plan and request enrollment for yourself or eligible dependents following the initial enrollment period, coverage will start on the first day of the month following the date the Employee Eligibility Statement is signed.

A statement that is more than 60 days old will be returned for updated information and signature, and the effective date will be the first of the month following the date the original enrollment form was received by Starmark or the group’s first anniversary, whichever is later. The pre-existing condition limitation applies.

Starmark’s sole focus is providing a flexible healthcare benefits portfolio and unparalleled personal service to small businesses with five to 50 employees. By offering HSA-compatible health plans and nationwide network access, plus cutting-edge resources such as easy and innovative paperless employee enrollment and valuable online healthcare decision support tools, Starmark continues to be a distinguished leader in small group healthcare benefits.