

INSTRUCTIONS: Top portion to be completed by the Employer. Remaining portions to be completed by the employee. Print clearly in dark ink, sign the form and return as instructed.

Group Name PHOENIX PAINTING INDUSTRY TRUST FUND	Group # JE882		Date of Hire:	Effective Date:
Enrollment for health, life, AD&D, Dental and Vision coverage.				
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add Newborn	<input type="checkbox"/> Late Enrollee		
<input type="checkbox"/> Annual/Open Enrollment	<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Special Enrollee (Please attach certificate of Creditable Coverage)		
<input type="checkbox"/> Reinstatement	<input type="checkbox"/> Change Personal Data	<input type="checkbox"/> Waive/Reduce Coverage		

Employee Name (Last, First, MI)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Phone Number
Employee Address (Street Address, City, State, Zip Code)		Beneficiary Designation: (attach an additional page if necessary)		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		Primary: _____ Relationship: _____ %: _____		
Date of Marriage: _____		Contingent: _____ Relationship: _____ %: _____		

OTHER INSURANCE INFORMATION

Are you, your spouse or any of your dependents covered by any other medical insurance plan? Yes No
 Medicare? Yes No
 If yes, attach a copy of your Medicare Card
 Please indicate the type of other coverage indicated above:
 Medical Dental Vision Prescription Drug Plan

Name of Insured Covered by Other Medical Insurance Plan	Name and Address of Other Medical Insurance Plan	Telephone No. of Other Medical Insurance Plan	Group or I.D. Number	Effective Date of Coverage

COMPLETE ONLY IF COVERAGE INCLUDES DEPENDENT COVERAGE:

(attach an additional page if necessary)

Dependent's Full Name	Relationship	Sex	Social Security Number	Birth Date	Full Time Student	Other Medical Insurance
	<input type="checkbox"/> Spouse	<input type="checkbox"/> M <input type="checkbox"/> F			N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

The information on this form shall replace any previously dated forms that may be on file.

THIS FORM WILL NOT BE ACCEPTED BY TRUSTMARK LIFE INSURANCE COMPANY UNLESS SIGNED AND DATED BY THE INSURED/EMPLOYEE.

**Please complete and attach the appropriate spousal/dependent verification form.*

Employee's Signature

Date



FRAUD WARNING

Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the entities listed in this authorization to give Trustmark, and through it, to its reinsurers and the Medical Information Bureau any financial or medical [MQ1] data or records in the entities possession about me or my mental or physical health. This authorization applies to financial or medical data or records about my spouse and any child proposed for insurance in this application. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; or the Medical Information Bureau [MQ2] which may have financial or medical information pertinent to determine my eligibility for insurance. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this authorization will be as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Trustmark. I understand that I may refuse to sign this authorization and still be assured treatment. (My authorized representative and I are entitled to receive a copy of this authorization.)