Administered by
Starmark®
A Trustmark Company
400 Field Drive • Lake Forest, IL 60045

For New Groups

Employee Eligibility Statement

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

*** 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. ****IMPORTANT NOTICE: This plan covers limited medical expenses only. This does not provide comprehensive major medical coverage.**

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.

Employer Information

COMPANY NAME	LOCATION (State, ZIP)	
Aerie Engineering	**Greenville, SC 29601**	
PLAN CHOICE (if available): DEDUCTIBLE	**PHYSICIAN/HOSPITAL NETWORK**	**GROUP Number (If available)**
Healthy Choices ($0 Deductible)	Referenced Based (no network)	

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 ☐ Not declared	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yyyy)	MARITAL STATUS ☐ Single ☐ Married
WORK PHONE	HOME 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
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 (include Special Enrollee Form AD41)

If no longer employed, but on COBRA or State Continuation, enter employment termination date (mm/dd/yyyy): _____

*** If your 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/State Continuation****
- ☐ Other (explain): _____

Employee Signature (if waiving coverage):

Signature: _____ **Date:** _____

✍ **ORIGINAL SIGNATURE REQUIRED. PRINT THEN SIGN.**

** If you are declining coverage for any reason other than COBRA/ State Continuation, please complete this section, sign above and return the application. If you are declining coverage due to COBRA/ State Continuation, please complete the entire eligibility statement.

OFFICE USE ONLY

UND _____ EFF _____ SUB _____

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 D Effective date: ________

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

Medical Information

Do not complete the medical information section below if applying for your employer's self-funded Preventive Care Plan.

Please answer yes or no to each item listed below:

1. Within the last 4 years, have you or any dependent applying for coverage received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following?

		Yes	No
A.	Alcohol or drug abuse	☐	☐
B.	Arthritis (Rheumatoid Arthritis, Osteoarthritis, Psoriatic, other)	☐	☐
C.	Autoimmune and/or connective tissue disorder, Lupus, Psoriasis or other Systemic disorder	☐	☐
D.	Blood disorder (including Anemia and Hemophilia)	☐	☐
E.	Cancer or tumor	☐	☐
F.	Congenital disorder	☐	☐
G.	Digestive disorder (other than acid reflux): includes colon, intestinal, stomach, esophageal.	☐	☐
H.	Growth disorder or hormone disorder (other than thyroid)	☐	☐
I.	Heart or circulatory (other than high blood pressure or cholesterol)	☐	☐
J.	HIV positive or AIDS	☐	☐
K.	Kidney, Liver or Pancreas	☐	☐
L.	Muscle or joint disorders	☐	☐
M.	Neurological (Multiple Sclerosis, Paralysis, Palsy, Seizures, Stroke, other)	☐	☐
N.	Respiratory (other than allergies or asthma)	☐	☐
O.	Reproductive disorder	☐	☐

2. EMPLOYEE'S HEIGHT________ WEIGHT________ SPOUSE/ DOMESTIC PARTNER'S (if applicable) HEIGHT________ WEIGHT________

3. Have you or your spouse/domestic partner used any tobacco products in the past 12 months?
Employee: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

		Yes	No
4.	Have you or any dependent(s) applying for coverage been hospitalized, had surgery, or had more than $5,000 in medical expenses in the last 12 months?	☐	☐
5.	Have you or your dependent(s) applying for coverage been advised that hospitalization or surgery **will be necessary** in the next 12 months?	☐	☐

As part of the routine underwriting procedure, you may receive a telephone call from the stop-loss insurance carrier's home office to obtain additional information. Please provide detailed medical information on this form to reduce the need for a phone interview. Your answers will be strictly confidential.

Within the last 4 years, have you or any dependent applying for coverage received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions for the following?

6. Pregnancy — Yes / No

Are you or your dependent(s) included in this enrollment currently pregnant? ☐ ☐

If no, proceed to question 7.

If yes, name of person who is pregnant: _____ Due Date: _____

Are multiple births expected? If yes, ☐ Twins ☐ Triplets ☐ Quadruplets ☐ Other ☐ ☐

Are there any known complications (i.e. eclampsia, gestational diabetes, etc.) ☐ ☐

If yes, please specify: _____

Is a cesarean section anticipated? ☐ ☐

7. Back/Neck — Yes / No

Have you or your dependent(s) received treatment or medication for a back/neck condition? ☐ ☐

If no, proceed to question 8.

If yes, name of person with the condition: _____

Diagnosis (i.e. herniated disc, scoliosis, sprain, etc.): _____

Date treatment started: _____ Date treatment ended: _____

Treatment received: _____ ☐ ☐

Current medication(s): name, dose and frequency: _____ ☐ ☐

Was this work related? ☐ ☐

If yes, is a third party paying the claims? ☐ ☐

Was this due to a Moving Vehicle Accident (MVA)? ☐ ☐

If yes, is a third party paying the claims? ☐ ☐

If yes, has the case been settled? ☐ ☐

Has future treatment or testing been recommended? ☐ ☐

If yes, what type of treatment or testing was recommended? _____

Anticipated date(s) of treatment or testing: _____

8. Diabetes or Pre-diabetes — Yes / No

Have you or your dependent(s) been diagnosed with diabetes or pre-diabetes? ☐ ☐

If no, proceed to question 9.

If yes, name of person with the condition: _____

Date diagnosed: _____

Current medication(s): name, dose and frequency: _____ ☐ ☐

Do you have an Insulin Pump already installed? ☐ ☐

Is an Insulin Pump recommended? ☐ ☐

Last blood sugar reading: _____ Date: _____

Last A1C reading: _____ Date: _____

Do you have a diabetic-related disorder (i.e. ulcers, kidney disorder, retinopathy, etc.)? ☐ ☐

If yes, details: _____

Has future treatment or testing been recommended? ☐ ☐

If yes, what type of treatment or testing was recommended? _____

Anticipated date(s) of treatment or testing: _____

9. Mental/Nervous — Yes / No

Have you or your dependent(s) been diagnosed with a mental/nervous condition? ☐ ☐

If no, proceed to next page.

If yes, name of person with the condition: _____

Diagnosis (i. e. depression, anxiety, bipolar, etc.) _____

Date diagnosed: _____

Current medication(s): name, dose and frequency: _____ ☐ ☐

Treatment, dates, and frequency of outpatient counseling (if applicable): _____

Have you been hospitalized for the condition? ☐ ☐

If yes, date(s) hospitalized for treatment: _____

Has suicide been attempted or threatened? ☐ ☐

Date(s): _____

Has future treatment or testing been recommended? ☐ ☐

If yes, what type of treatment or testing was recommended? _____

Anticipated date(s) of treatment or testing: _____

Medical Information (continued)

Please provide details for each YES answer on Page 2. If more space is needed, attach a separate sheet, sign and date it.

Question Number: ____________________

Person with the condition: ____________________ Exact diagnosis: ____________________

Date diagnosed: ____________________ Date last treated: ____________________

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking? **Yes**	**No**
			☐	☐
			☐	☐
			☐	☐

List all treatment received for this condition: ____________________

List all tests performed for this condition: ____________________

Results, readings and dates: ____________________

Any relapses or flare ups? ☐ Yes ☐ No Dates: ____________________

Have future tests, treatment, or surgeries been recommended? ☐ Yes ☐ No

If yes, what has been recommended? ____________________

Anticipated date(s): ____________________

Prognosis: ____________________

Question Number: ____________________

Person with the condition: ____________________ Exact diagnosis: ____________________

Date diagnosed: ____________________ Date last treated: ____________________

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking? **Yes**	**No**
			☐	☐
			☐	☐
			☐	☐

List all treatment received for this condition: ____________________

List all tests performed for this condition: ____________________

Results, readings and dates: ____________________

Any relapses or flare ups? ☐ Yes ☐ No Dates: ____________________

Have future tests, treatment, or surgeries been recommended? ☐ Yes ☐ No

If yes, what has been recommended? ____________________

Anticipated date(s): ____________________

Prognosis: ____________________

Question Number: ____________________

Person with the condition: ____________________ Exact diagnosis: ____________________

Date diagnosed: ____________________ Date last treated: ____________________

List all medication(s) prescribed for this condition:

Name:	Dosage:	Frequency:	Currently taking? **Yes**	**No**
			☐	☐
			☐	☐
			☐	☐

List all treatment received for this condition: ____________________

List all tests performed for this condition: ____________________

Results, readings and dates: ____________________

Any relapses or flare ups? ☐ Yes ☐ No Dates: ____________________

Have future tests, treatment, or surgeries been recommended? ☐ Yes ☐ No

If yes, what has been recommended? ____________________

Anticipated date(s): ____________________

Prognosis: ____________________

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 Starmark underwriting immediately by sending an e-mail to STMUW@starmarkinc.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

Starmark 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 Starmark 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.

☐ **YES, I AGREE TO RECEIVE EMPLOYEE BENEFIT DOCUMENTS INCLUDING, BUT NOT LIMITED TO: PLAN DOCUMENTS, SUMMARY PLAN DESCRIPTIONS, SUMMARY OF BENEFITS AND COVERAGE, POLICIES, CONTRACTS, AGREEMENTS, LETTERS AND NOTICES THROUGH ELECTRONIC MEDIA USING A COMPUTER WITH INTERNET ACCESS. I UNDERSTAND I CAN RECEIVE PRINTED DOCUMENTS AT NO COST AFTER I NOTIFY STARMARK OF MY CHANGE IN PREFERENCE.**

Employee Signature _____ Date _____

✍ **ORIGINAL SIGNATURE REQUIRED. PRINT THEN SIGN.**

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 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 your 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 enrollment period, which is the month prior to the start of the new plan year.

The following notice applies to preventive care coverage plans:

This plan does not provide comprehensive major medical coverage. Benefits are limited. This preventive benefits plan 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.

Go Green! Opt in to the Starmark® Document Center to:

- Access important health plan documents such as your Plan Document, and Summary of Benefits and Coverage online through your secure Starmark Account.
- Stop mail delivery and delays. The Document Center gives immediate access to important documents. You'll receive an email notification when a new document is available.
- Stop combing through paper documents. Your online documents are searchable using the PDF search feature.

Plus, opting in to the Document Center is easy. Simply check "yes, I agree" before signing the Employee Eligibility Statement, then opt in when you register at www.starmarkinc.com.