ENROLLMENT FORM

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

TO BE COMPLETED BY EMPLOYER

COMPANY NAME	GROUP NUMBER	DATE OF HIRE	EFFECTIVE DATE

PPO OPTION	DIVISION #/NAME	DEPARTMENT # / NAME (if applicable)

☐ New Enrollment ☐ Marriage ☐ Retirement
☐ Open Enrollment ☐ Change Name ☐ Address Change
☐ Change Employment Status ☐ Unpaid Leave of Absence ☐ Other _____

EMPLOYEE INFORMATION:

LAST NAME	MI	FIRST NAME	DATE OF BIRTH

ADDRESS

CITY	STATE	ZIP	GENDER	MARITAL STATUS
			☐ M ☐ F	☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

SOCIAL SECURITY NUMBER	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

EMPLOYEE FAMILY PHYSICIAN NAME OR PRACTICE NAME	PHYSICIAN ADDRESS	PHYSICIAN PHONE

Is your spouse employed? ☐ YES ☐ NO Is your spouse eligible for Health benefits through employer? ☐ YES ☐ NO
Is your spouse covered under this employer Plan? ☐ YES ☐ NO

Name & Address of Spouse's Insurance Company: Policy Number:

Name & Address of Spouse's Employer:

HEALTH BENEFIT OPTIONS: **LEVEL OF COVERAGE:**

MEDICAL ☐ YES ☐ NO ☐ Employee ☐ EE/SP ☐ EE/Child(ren) ☐ Family

DEPENDENT INFORMATION: List spouse and any dependent child who will be covered under your Health Benefit Option.

Dependent #1: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship
			☐ M ☐ F	☐ Spouse ☐ Son ☐ Dgtr ☐ Other
Dependent Physician or Practice Name	**Physician Address**			**Physician Phone**
Dependent Contact Phone	**Dependent Email**		Is this dependent covered under any other health coverage? ☐ YES ☐ NO	

Dependent #2: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship
			☐ M ☐ F	☐ Spouse ☐ Son ☐ Dgtr ☐ Other
Dependent Physician or Practice Name	**Physician Address**			**Physician Phone**
Dependent Contact Phone	**Dependent Email**		Is this dependent covered under any other health coverage? ☐ YES ☐ NO	

Dependent #3: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship
			☐ M ☐ F	☐ Spouse ☐ Son ☐ Dgtr ☐ Other
Dependent Physician or Practice Name	**Physician Address**			**Physician Phone**
Dependent Contact Phone	**Dependent Email**		Is this dependent covered under any other health coverage? ☐ YES ☐ NO	

Dependent #4: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship
			☐ M ☐ F	☐ Spouse ☐ Son ☐ Dgtr ☐ Other
Dependent Physician or Practice Name	**Physician Address**			**Physician Phone**
Dependent Contact Phone	**Dependent Email**		Is this dependent covered under any other health coverage? ☐ YES ☐ NO	

Dependent #5: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship
			☐ M ☐ F	☐ Spouse ☐ Son ☐ Dgtr ☐ Other
Dependent Physician or Practice Name	**Physician Address**			**Physician Phone**
Dependent Contact Phone	**Dependent Email**		Is this dependent covered under any other health coverage? ☐ YES ☐ NO	

☐ I authorize my employer to deduct the appropriate contribution from my earnings, if applicable.

☐ I do not desire employee coverage ☐ I do not desire dependent coverage

I understand that a qualified change in Family Status or Loss of Coverage(Special Enrollment) will be required to enroll at a later date.

I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, and others who have legitimate need for such information for the purpose of review, investigation or evaluation of a claim, to supply to each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is valid as the original.

Date: _____ Signature: _____