Trustmark
benefits beyond benefits

Small Business Benefits

Simplified Underwriting Risk Review Form

Any person who intends to defraud or knowingly facilitates fraud against an insurer, submits applications or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Full Legal Name of Employer			
Employer Plan Sponsor-Responsible Party		Job Title	
Address (Employer Headquarters)		Phone	Website Address
City/State	ZIP Code	Email Address	
Renewal Date	Total Covered Employees on the Current Plan		
Is Current Group Medical Coverage ☐ Fully Insured ☐ Level-Funded ☐ Self-Funded			
Name of Current Group Medical Carrier			In Effect Since
Broker Name			Phone

I confirm I have reviewed all records and information available to me in answering the following questions regarding all plan participants and dependents including those on COBRA. ☐ Yes ☐ No

A. Have you received paid claims, large claimant or utilization reports in the last 6 months? If yes, please provide information received. ☐ Yes ☐ No

B. Have any employees or dependents, including those on COBRA, been hospitalized, had surgery or had more than $10,000 in medical expenses in the last 12 months? ☐ Yes ☐ No

C. Are any employees or dependents currently pregnant? ☐ Yes, how many? _____ ☐ No

D. Have any employees or dependents, including those on COBRA, been advised that hospitalization or surgery will be necessary in the next 12 months? ☐ Yes ☐ No

E. Has any employee or plan participant been absent for more than 5 consecutive workdays in the past 12 months for their own or their dependents accident or illness? ☐ Yes ☐ No

F. Within the past 4 years, has any employee or dependent, including those on COBRA, received or are scheduled to receive treatment for any of the following disorders or conditions?

a. Transplant . . . . . ☐ Yes ☐ No
b. End Stage Renal Disease . . . . . ☐ Yes ☐ No
c. Cancer. . . . . ☐ Yes ☐ No
d. Receiving injectable medications?. . . . . ☐ Yes ☐ No

If you answered "Yes" to B, C, D, E or F, please provide the following details: (If needed, please include an additional page)

Question	Disorder/Condition	Dates of Treatment	Medications	Prognosis/Current Treatment

I represent to the best of my knowledge the information provided is accurate. I understand the data included in this form is used in underwriting and shall be relied upon in determining rates. Trustmark Life Insurance Company has the right to revise rates retrospectively or prospectively for the stop-loss insurance contract if false, incomplete or misleading information is provided in this form, or failure to notify Trustmark Life Insurance Company of any changes to the answers to the medical questions above resulting in material misrepresentation affecting the assessment of the risk or terms or conditions for coverage. I also understand a change in final enrolled census could result in a change in rate.

Employer/Plan Sponsor Responsible Party (Signature) _____ Date _____

Cannot be signed more than 90 days from the requested effective date.

Self-funded plans are administered by Star Marketing and Administration, Inc., and stop-loss insurance and ancillary coverage are provided by Trustmark Life Insurance Company