Instructions for Accident Insurance Application

Be sure to mail or fax this application to The MPM Group on or before **Friday, May 15, 2015**. Do not mail to Trustmark. The Effective Date for all policies will be July 1, 2015.

Mailing Address:

The MPM Group
1010 Monarch St., Suite 220
Lexington, KY 40513

Fax: (859) 224-1288

When completing the application:

1. Your Employer should be one of the following:
   University of Kentucky
   CKMS
   Eastern State Hospital
   KCTCS

2. Be sure to fully complete personal information.

3. For "Deduction Mode", check either 12 or 26 if you work for UK, check 26 if you work for ESH or CKMS, or check 24 if you work for KCTCS.

4. List all members to be covered.

5. "Premium Amount" can be found in this table:

Coverage Level	Bi-Weekly (26)	Semi-Monthly (24)	Monthly (12)
Employee Only	$8.03	$8.70	$17.41
EE & Spouse	$12.20	$13.22	$26.44
EE & Child(ren)	$14.38	$15.58	$31.16
Family	$18.55	$20.10	$40.20

6. Do not check any boxes regarding the Plan. They have already been marked.

7. Please answer the question regarding "actively at work".

8. Please answer the question regarding "spouse on disability" (if spouse is to be covered).

9. Please list a Beneficiary.

10. **PLEASE BE SURE TO SIGN APPLICATION.**

Don't hesitate to call us with questions at (859) 223-4973 or Toll Free (888) 388-1676.

TRUSTMARK INSURANCE COMPANY
400 Field Drive, Lake Forest, IL 60045

☒ **Application for Accident Coverage**
☐ **Application for Reinstatement of Accident Coverage**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

APPLICANT INFORMATION

Employer: | Employee I.D. #: | Annual Salary: $ 0.00 | ☐ Full-Time ☐ Part-Time

Location: | Department: | Email Address:

Social Security No.: | Date of Hire: | Home Phone No.:

Employee: | Birth Date: | Sex: ☐ M ☐ F | Deduction Mode: ☐ 52 ☐ 26 ☐ 24 ☐ 20 ☐ 12 ☐ 11 ☐ 10 ☐

Home Address: (Street) | (City) | (State) | (Zip)

COVERAGE FOR: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

List all eligible persons to be covered on this plan: Employee; Spouse; and Your Children age 25 or under

Name(s)	DOB	Relationship	Gender
EMPLOYEE	(as above)	Self	☐ M ☐ F
		Spouse	☐ M ☐ F
		Child 1	☐ M ☐ F
		Child 2	☐ M ☐ F
		Child 3	☐ M ☐ F
		Child 4	☐ M ☐ F
		Child 5	☐ M ☐ F

☒ 24-Hour Coverage
☐ Hospital Plan: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐ 6
☐ Wellness Benefit Rider:
☐ $60 Per Visit ☐ $120 Per Visit
☒ Health Screening Rider:
☐ $50 Per Year ☒ $100 Per Year
☒ Catastrophic Accident Benefit
☒ Accidental Death Benefit
☐ Accident Disability Spouse Benefit
☐ Loss of Work Rider

☐ Accident Disability Benefit – Non-Occupational Coverage Only:

Employee Amount: $ N/A per month

Premium Amount: $ _____

1. Are you actively at work at least 17 hours per week performing all of the normal duties of your usual occupation? . . . . . ☐Yes ☐No

2. If Spouse to be covered: Is spouse currently disabled? . . . . . ☐Yes ☐No

Beneficiary: a) Primary: _____ Relationship: _____

Remarks or Special Requests

If this application has been completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. I acknowledge that Trustmark or its agent has verified my identity for this purpose in accordance with any applicable law or regulation. The responses received on this application form will be attached and made part of the Policy/Certificate.

I represent that all statements and answers given in this application are complete and true. I agree that all such statements and answers shall be made part of any insurance issued. Any misstatements or misrepresentation on the application may result in loss of coverage. If coverage cannot be issued as applied for, I authorize Trustmark to reduce benefits that are acceptable to Trustmark, and to adjust premiums to match the coverage issued. This authorization does not create any additional obligation by Trustmark to issue coverage to any proposed insured.

Acknowledgment – I have received and read a copy of the Company's Notice about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; 3) the Notice of Information Practices; and 4) the Disclosure Outline, if required.

I understand that: 1) the insurance will be effective on the date assigned by Trustmark; and 2) I must be actively at work at my employer named above on the first premium payroll deduction date, to be eligible for insurance. Coverage may be provided under a Policy issued to a trust.

Application made at _____
City State

X _____
Signature of Proposed Insured

This _____
Month Day Year

_____
Signature of Agent

Agent Renewal # _____

HOME OFFICE CORRECTIONS	AGENT COMMENTS