EMPLOYER SECTION:

Hire Date: ____ Effective Date: ____

Business Unit: ____ Salary: ____

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

PERSONAL DEMOGRAPHICS

Social Security #: ____ Employee First Name: ____ Employee Last Name: ____ Gender: ____

Street Address: ____ City: ____ State: ____ Zip: ____ Date of Birth: ____

Home Phone: ____ Mobile Phone: ____ Employee Status ____

Family Status: ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ Electronic EOB Email Address: ____

YOUR FAMILY

Name of Insured: (First, Last & M.I.)	SS #	Date of Birth:	Relationship	Gender:	PPO 500	HSA 1300	HSA 2000
			Employee		☐	☐	☐
			Spouse		☐	☐	☐
			Dependent		☐	☐	☐
			Dependent		☐	☐	☐
			Dependent		☐	☐	☐

Dental Coverage: Employee Only ☐ Employee+1 ☐ Full Family ☐

Vision Coverage: Employee Only ☐ Employee+1 ☐ Full Family ☐

AUTHORIZATION /ASSIGNMENT

I hereby apply for benefits under the group benefit plan(s) provided by my employer subject to all of its terms, conditions and provisions. I represent that all information provided above is true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements about myself or my named dependents may result in claim denial or termination of coverage if such information materially affects eligibility for coverage. If a contribution towards the cost is required, I authorize the necessary deductions from my earnings. I further authorize and direct that all benefit payments be made directly to the health care provider rendering a health care service payable under the plan(s).

Signature: ____ Date: ____