

**TRUSTMARK INSURANCE COMPANY  
TRUSTMARK LIFE INSURANCE COMPANY**

**LIST OF AUTHORIZED REPRESENTATIVES**

The following individuals perform administrative functions for my group health plan and may have access to Protected Health Information (PHI) or summary health information. These individuals are authorized to discuss PHI that is the minimum necessary to administer the group health plan.

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name and/or Title of Person: \_\_\_\_\_

Company Name: \_\_\_\_\_

How does the Authorized Person use or disclose PHI in the performance of their job duties?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and/or Title of Person: \_\_\_\_\_

Company Name: \_\_\_\_\_

How does the Authorized Person use or disclose PHI in the performance of their job duties?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and/or Title of Person: \_\_\_\_\_

Company Name: \_\_\_\_\_

How does the Authorized Person use or disclose PHI in the performance of their job duties?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(If more space is needed, please use another sheet of paper.)

If there are any changes to be made to this list, additions or deletions, the plan sponsor is required to notify us within 30 days of the change.

Signed by: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_