

**TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY
LIST OF AUTHORIZED REPRESENTATIVES
(CHANGES TO ORIGINAL LIST)**

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. We are changing our existing list of authorized representatives and have indicated whether this person is new (ADD), should be deleted (DELETE) or there is change to the information previously given on an existing authorized person (CHANGE).

Group Name: _____ Group Number: _____

ADD DELETE CHANGE

Name and/or Title of Person: _____

Company Name: _____

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

ADD DELETE CHANGE

Name and/or Title of Person: _____

Company Name: _____

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

ADD DELETE CHANGE

Name and/or Title of Person: _____

Company Name: _____

Name and/or Title of Person: _____

Company Name: _____

(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: _____