

**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. **\*\*\*The primary function must be described in detail and all duties specifically outlined. If more space is needed, please use another sheet of paper.**

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

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

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

**\*KEY – for Primary Function(s) usage of information:**

**LMTD:** Limited access - an individual who works with enrollment, termination, COBRA, etc. – needs no additional health information)

**CLMS 1:** Individual who needs to check status of claims – minimal PHI to include eligibility information

**CLMS 2:** Assists participants in filing claims or appeals on claims denials – should have access to all claims data, including eligibility, upon request)

**FINANCE:** Individual to whom we are to deliver reports related to financial maintenance of the coverage (e.g. check register, etc.)

**Primary Function(s)\* with regard to the group health benefit plan:**

LMTD       CLMS 1       CLMS 2       FINANCE       OTHER

If other, how does the Authorized Person use or disclose PHI in the performance of their job duties?

\_\_\_\_\_  
\_\_\_\_\_

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

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

**Primary Function(s)\* with regard to the group health benefit plan:**

LMTD       CLMS 1       CLMS 2       FINANCE       OTHER

If other, how does the Authorized Person use or disclose PHI in the performance of their job duties?

\_\_\_\_\_  
\_\_\_\_\_

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

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

**Primary Function(s)\*\*\* with regard to the group health benefit plan:**

LMTD       CLMS 1       CLMS 2       FINANCE       OTHER

If other, 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: \_\_\_\_\_