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: __________________________

***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.)

☐ ADD ☐ DELETE ☐ CHANGE

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?
____
____

☐ ADD ☐ DELETE ☐ CHANGE

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?
____
____

☐ ADD ☐ DELETE ☐ CHANGE

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?
____
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(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: ______________________________