CORESOURCE
A Trustmark Company

ANNUAL COVERAGE VERIFICATION FORM

To Be Completed By Employee

EMPLOYER NAME	EMPLOYER ADDRESS	GROUP NO. ARMETO1
EMPLOYEE NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY NO.

ARE ANY BENEFITS AVAILABLE FROM: (CIRCLE YES OR NO)	EMPLOYEE	SPOUSE	DEPENDENT CHILDREN
A. ANY OTHER GROUP HEALTH INSURANCE PLAN?	YES NO	YES NO	YES NO
B. ANY OTHER DENTAL PLAN?	YES NO	YES NO	YES NO
C. HEALTH MAINTENANCE ORGANIZATION (HMO)?	YES NO	YES NO	YES NO
D. MEDICARE?	YES NO	YES NO	YES NO

REMARKS: IF YOU HAVE INDICATED "YES" TO ANY OF THE ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE OTHER COVERAGE.

POLICY NUMBER	CERTIFICATE NUMBER
EFFECTIVE DATE	NAME OF INSURED
NAME & ADDRESS OF INSURANCE COMPANY	(TELEPHONE NUMBER)
NAME & ADDRESS OF EMPLOYER OR ORGANIZATION (SCHOOL OR UNION) WHICH SPONSORS THE COVERAGE	(TELEPHONE NUMBER)

LIST WHO IS COVERED UNDER THE OTHER INSURANCE PLAN

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	D.O.B. MO./DAY/YR.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This form will authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me and/or my family, or our health, to give CoreSource, a reinsurer, the Medical Information Bureau or any authorized organization, any such information. This information is used in claims administration and underwriting. A copy of this authorization shall be considered as effective and valid as the original within the year and date signed, unless revoked in writing at an earlier date. I certify that all information contained on this form is true and accurate. I will promptly notify my employer with any changes in the status of this information.

Date Signed:_____ Employee Signature:_____

Date Signed:_____ Spouse's Signature (if covered):_____

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