

Personal Information – If you enroll in a HMO medical plan, you MUST indicate your network Primary Care Physician (PCP), Woman's Principal Health Care Provider (WPHCP), if applicable, and their contracting Medical Group name and number. Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group.

| | | | |
|---|--|-----------------------|---|
| SSN# | Last | First | MI |
| Street Address | | City | State ZIP |
| Email Address | | Home Phone () | Cell Phone () |
| Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married | Birth Date (mm/dd/yy) | Hire Date (mm/dd/yy) |
| PCP's Medical Group # _ _ _ _ | PCP's Medical Group Name | PCP's Name | WPHCP's Name (must be in same Medical Group as PCP) |

Coverage Election

| | | | | |
|-------|--|-----------------------------------|---------------------------------|---------------------------------|
| PLAN: | <input type="checkbox"/> BlueAdvantage HMO | <input type="checkbox"/> BCBS PPO | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
|-------|--|-----------------------------------|---------------------------------|---------------------------------|

Complete Family Information. HMO Enrollees: Each family member may select a different contracting Medical Group, PCP, and WPHCP (Woman's Principal Health Care Provider). Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group. For additional dependents, please complete another enrollment form.

| | | | | |
|---|-------|--------------------------|--------------------------|----------------------------------|
| Medical: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Dental: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |
| Vision: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Medical: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |
| Dental: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Vision: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |
| Medical: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Dental: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |
| Vision: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Medical: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |
| Dental: <input type="checkbox"/> Add <input type="checkbox"/> Drop | First | Last (if different) | Date of Birth (mm/dd/yy) | Relationship to Participant |
| Vision: <input type="checkbox"/> Add <input type="checkbox"/> Drop | SSN# | PCP's Medical Group Name | | PCP's Medical Group # _ _ _ _ |

Health Flexible Spending Account
Dependent Care Flexible Spending Account

| | | | | | |
|---|---------------------------------|----------------------------------|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Enroll | <input type="checkbox"/> Change | <input type="checkbox"/> Decline | <input type="checkbox"/> Enroll | <input type="checkbox"/> Change | <input type="checkbox"/> Decline |
| I. Contribution Amount: | | | I. Contribution Amount: | | |
| II. Number of regular pay periods: | | | II. Number of regular pay periods: | | |
| III. Contribution/pay period (I divided by II): | | | III. Contribution/pay period (I divided by II): | | |

Life and Disability Plans

| Group AD&D | Company-Paid Benefit | |
|--|--|--|
| EE - Optional Life | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary <input type="checkbox"/> 3x salary <input type="checkbox"/> 4x salary <input type="checkbox"/> 5x salary Guaranteed Issue amount of 3x salary (newly eligible) \$750,000 maximum coverage |
| EE - Optional Accidental Death and Dismemberment | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary <input type="checkbox"/> 3x salary <input type="checkbox"/> 4x salary <input type="checkbox"/> 5x salary Guaranteed Issue amount of 3 x salary (newly eligible) \$750,000 maximum coverage (must enroll in optional EE life) |
| Spouse - Optional Life | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coverage amount \$ _____ (Increments of \$10,000) Guaranteed Issue amount of \$100,000 \$250,000 maximum coverage |
| Spouse - Optional Accidental Death and Dismemberment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coverage amount \$ _____ (Increments of \$10,000) Guaranteed Issue amount of \$100,000 \$250,000 maximum coverage (must enroll in optional spouse life) |
| Child - Optional Life | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 |
| Child - Optional Accidental Death and Dismemberment | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 (must enroll in optional child life) |
| Short-Term Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No | 60% of weekly pre-disability earnings up to \$1,000 |
| Long-Term Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No | 65% of monthly pre-disability earnings up to \$8,000 |
| Critical Illness - Employee | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 |
| Critical Illness - Spouse/Domestic Partner | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 |
| Critical Illness - Child(ren) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 |

Other Group Health Insurance Information – If you or any member of your family have other group health insurance please provide the following.

| | | | |
|------------------------|-------------|-----------------------|---------------|
| Insured's Name | Employed By | Birth Date (mm/dd/yy) | Policy Number |
| Insurance Company Name | Address | City | State ZIP |

I elect coverage under the above-selected Plan(s) on behalf of myself and the above-listed dependents, and authorize any payroll deductions required.

I certify that all information furnished by me on this application is true and complete to the best of my knowledge.

I understand that the services listed in the health insurance certificates will be available, subject to the Term and Conditions thereof, beginning with hospital admissions or medical care rendered, on or after the coverage date set by each insurance carrier.

I understand that insurance carrier use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

I understand that I will not have the opportunity to change or cancel my medical plan until the next Open Enrollment period (unless it is within 31 calendar days of a qualifying family status change).

This authorization is to remain in effect until my notification to the contrary.

Signature of Employee: _____ Date: _____