Enrollment Form / Change Form

Please complete this application in FULL or it will be returned, resulting in a delay in processing. You are solely responsible for its accuracy and completeness. Enrollment must occur within 30 days from the date that you or your dependent(s) become eligible.

Purpose - Dates Required

Check All That Apply

- ❑ New Hire
- ❑ Re-Hire Date:________
- ❑ Part Time to Full Time
  Date FT: ____________
- ❑ Name Change
- ❑ Demographic Change
- ❑ Salary Change
- ❑ Change Plan Option

Employer's Responsibility

- ❑ **Termination** (indicate COBRA eligible below):
- ❑ Terminate Coverage (All Members)
- ❑ Terminate Dependent(s) Coverage

____________________ **Term Date** (end of month; Life/Disability last day worked)
____________________ **Reason for Termination of Benefits**
____________________ **Last Day Worked**

*Late notifications may be subject to Texas SB51 or similar applicable state insurance legislation *

Qualifying Event - Dates Required (enrollment must occur within 30 days of event and provide proper documentation)

- ❑ Add Dependent
- ❑ Terminated Dependent
- ❑ Dependent Aged Out
- ❑ Terminate - Other Coverage
- ❑ Job Status Change
- ❑ Reduction of Hours
- ❑ Medicare Eligible
- ❑ Other: _______________

Effective Date of QE: ______________________

Reason: ❑ marriage ❑ divorce ❑ birth ❑ death ❑ court order** ❑ adoption** ❑ loss/gain of coverage**

**provide supporting documents

For verification purposes, employees must provide supporting eligibility documentation for Plan Administrator to process your benefits change request. Acceptable forms of documentation may include, but is not limited to: court orders, child support order, adoption record or placement for adoption, letter from employer or health insurance company indicating coverage beginning or end date and COBRA documentation showing length of coverage with beginning and end dates.

Employer's Responsibility:

Date of Hire	Effective Date (based on eligibility waiting period)	Salary	❑ Hourly ❑ Weekly	❑ Monthly ❑ Annual

Employee Information

Social Security Number	❑ Male ❑ Female	Date of Birth (MM/DD/YYYY)	Marital Status	❑ Single ❑ Divorced	❑ Married ❑ Widow
Last Name	MI	First Name	Suffix		
Address 1	Address 2	City	State	Zip Code	
Primary Phone Number	Email Address				
Job Title	Job Class	Hours Worked Per Week			

Dependent Information

Your eligible dependents include: (a) your legal spouse; (b)Your dependent children who are under age 26; (c) your legally adopted children, if they depend on you for most of their support and maintenance; (d) your step children.

Names of Covered Family Members	Domestic Partner	Gender		DOB	SSN	Add/Remove	
Spouse:	❑	❑ Male	❑ Female			❑ A	❑ R
Child:		❑ Male	❑ Female			❑ A	❑ R
Child:		❑ Male	❑ Female			❑ A	❑ R
Child:		❑ Male	❑ Female			❑ A	❑ R
Child:		❑ Male	❑ Female			❑ A	❑ R
Child:		❑ Male	❑ Female			❑ A	❑ R

Please indicate your enrollment elections by checking the appropriate Boxes

Dental (per pay period)

Lincoln Financial Group **Policy # 0001D039891/92**

Dental Plan 1 - PPO

❑ Employee Only	$41.79
❑ Employee + Spouse	$85.89
❑ Employee + Child(ren)	$94.36
❑ Employee + Family	$147.22

Dental Plan 2 - DHMO

❑ Employee Only	$11.75
❑ Employee + Spouse	$22.90
❑ Employee + Child(ren)	$24.78
❑ Employee + Family	$35.82

*If you are electing the DHMO and do not list a provider one will be chosen for you. If you wish to change providers at any time you may do so by calling customer service by the 15th of the month and to be effective on the 1st of the following month.

Selected DHMO provider:_______________________________

- ❑ Waive
- ❑ COBRA eligible

Reason for waiving: ❑ Spouse / Parent plan ❑ Cost ❑ Medicare / Medicaid ❑ Other reason: ___________________ ❑ Individual Policy

Vision (per pay period)

VSP **Policy # 30099673**

Base Plan

❑ Employee Only	$10.33
❑ Employee + Spouse	$18.16
❑ Employee + Child(ren)	$18.53
❑ Employee + Family	$29.88

Buy Up Plan

❑ Employee Only	$12.57
❑ Employee + Spouse	$22.88
❑ Employee + Child(ren)	$23.35
❑ Employee + Family	$37.65

- ❑ Waive
- ❑ COBRA eligible

Reason for waiving: ❑ Spouse / Parent plan ❑ Cost ❑ Medicare / Medicaid ❑ Other reason: ___________________ ❑ Individual Policy

Basic Term Life and AD&D (Employer Paid)

Lincoln Financial Group — **Policy #** 000010255658

■ Benefit Amount **$25,000**

Life Insurance Beneficiary Designation - ALL EMPLOYEES MUST COMPLETE THIS SECTION

Primary Beneficiary Designation

Provide below the person(s) who should receive proceeds in the event of your death.
You may specify as many individuals as you like, but the total percent share of proceeds must equal 100%.

Please Note: If no beneficiary is designated, assets will be payable to the Estate of the insure

Full Name	DOB	Relationship	SSN	% of Assets

Contingent Beneficiary Designation (optional)

Provide below the person(s) who should receive proceeds ONLY if all your Primary Beneficiary(ies) listed above are not living at the time of your death.
If listing multiple persons, the total proceeds must equal 100%.

Full Name	DOB	Relationship	SSN	% of Assets

Voluntary Term Life and AD&D (per pay period)

Lincoln Financial Group — **Policy #** 000400255660

YOU MUST ELECT COVERAGE FOR YOURSELF IN ORDER TO COVER YOUR DEPENDENTS

Employee Life and AD&D Options: (AD&D election will mirror Life election) **Increments of $10,000** **(up to 5x annual salary maximum $300,000)**

- ❑ $10,000
- ❑ $20,000
- ❑ $30,000
- ❑ $40,000
- ❑ $50,000
- ❑ $60,000
- ❑ $70,000
- ❑ $80,000
- ❑ $90,000
- ❑ $100,000
- ❑ **150,000***
- ❑ Other Amount $_____________

(anything over $150,000 will require additional medical information)

❑ Waive

Life and AD&D Rates: (per $1,000 of benefit) **Maximum of $300,000; Not to exceed 5X annual salary**

Age	Rate	Age	Rate	Age	Rate	Age	Rate
18-29	$0.065	40-44	$0.165	55-59	$0.635	70-74	$2.525
30-34	$0.075	45-49	$0.235	60-64	$0.655	75-79	$7.535
35-39	$0.105	50-54	$0.415	65-69	$1.195	80+	$16.255

Spouse Life and AD&D Options: (AD&D election will mirror Life election) **Increments of $5,000** **(up to 50% of the employee life amount maximum $150,000)**

- ❑ $5,000
- ❑ $10,000
- ❑ $15,000
- ❑ $20,000
- ❑ $25,000
- ❑ **$30,000 ***
- ❑ $35,000
- ❑ $40,000
- ❑ $45,000
- ❑ $50,000
- ❑ $55,000
- ❑ Other Amount $_____________

(anything over $30,000 will require additional medical information)

❑ Waive

Life and AD&D Rates * : (per $1,000 of benefit) **Maximum of $150,000; Not to exceed 2.5 times the employee's salary**

Age	Rate	Age	Rate	Age	Rate	Age	Rate
18-29	$0.065	40-44	$0.165	55-59	$0.635	70-74	$2.525
30-34	$0.075	45-49	$0.235	60-64	$0.655	75-79	$7.535
35-39	$0.105	50-54	$0.415	65-69	$1.195	80+	$16.255

***Spouse rates are based on the employees age**

Child Life Options: **Increments of $10,000**

❑ $10,000 **Life Rates: (per $10,000 of benefit)**

Life	$2.00

❑ Waive

The voluntary life coverage includes Guarantee Issue coverage in the amount of $150,000 for Employee, $30,000 for Spouse and $10,000 for Child(ren). This applies to all eligible employees enrolling in the Voluntary Term Life/AD&D plan during their new hire eligibility period. If coverage is not applied for during the new hire eligibility period and coverage is requested at a later date, the full amount of coverage being applied for will be subject to medical underwriting and an Evidence of Insurability (EOI) form will be required. Please contact Human Resources to obtain the EOI form

Supplemental Plans

Colonial — **Policy # E5335923 / C7985187**

Colonial Life Supplemental Insurance Plans **- See benefit guide for plan options.**
If interested, complete the Colonial Interest Form and a Benefit Counselor will contact you.
All elections and/or plan changes must be administered by a Benefit Counselor.

Acknowledgement and Signature

Fraud Warning: Any person who, with intent to defraud by knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I verify that the information provided in this enrollment form is accurate and complete. I understand that if I have declined Voluntary Life and request to purchase such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) the insurance carrier will have the right to refuse my request.

I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan (Section 125), and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or if I experience a significant change in family status (called a "Life Event") such as, gaining or losing dependents through Birth, Death, Marriage, Divorce, or gaining or losing other health coverage, etc. I understand that I must make any changes within 30 days of the approved "Life Event." I understand that by not applying for the coverages contained herein, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for approval. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed. Additionally, I agree, for myself and for any eligible dependent listed, to abide by the rules and regulations of the plan, terms and conditions of all the Service Agreements for the Plans I have elected.

Signature ______________________ **Print Name** ______________________

Date ______________________ **Authorized Company Signature** ______________________

I verify that the termination information provided is accurate and complete.