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 Group # Section # Dept # Social Security Number

 Group # Section # Dept # Category

SECTION 1 — ENROLLMENT EVENTS PLEASE CHECK ALL THAT APPLY - IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2 AND 10 ONLY.

New Enrollee Add Dependent
 Are you applying as a result of a Special Enrollment Event? Yes No If yes, select
 Event: Marriage Birth, Adoption, Suit for Adoption
 Court Order (see instructions)
 Loss of Other Coverage (provide Certification of Coverage)
 Other (Explain): _____
 Indicate Event Date: ___/___/___

Add Coverage: Health Dental
 Term Life Dependent Life
 Short Term Disability (STD)
 Long Term Disability (LTD)
 Change Address/Name

Cancel Enrollee Cancel Dependent
 List names of those canceling in Section 4 below
 Event: Divorce Death
 Terminated Employment
 Other
 Indicate Event Date: ___/___/___

Cancel Coverage: Health Dental Term Life
 Dependent Life STD LTD

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name First Name Middle Initial (opt) Date of Birth Social Security Number

Mailing Address - Street - Apt# City State Zip

E-Mail Address (opt) Male Female Business Phone # Home Phone #

Name of Employer Date of Employment Do you usually work at least 30 hours a week for this employer?
DunderMifflin Paper Company _____ Yes No

Eligibility Status: Active Employee Retired Employee - Date of Retirement: _____ COBRA Continuation
 Continuation of Group Coverage (insured plans only) Dependent Continuation of Group Coverage (insured plans, only)

SECTION 3 — SELECT YOUR COVERAGE PLEASE CHECK ALL THAT APPLY

Health Plan (select one)
 Plan 1: CoPay (M04)
 Plan 2: HSA (MH1)
Health Coverage Selection (select one)
 Employee Only
 Employee /Spouse
 Employee /Child(ren)
 Family
 I am **not** applying for **Health** coverage

Dental Plan (select one)
 Plan 1 (Traditional)
 Plan 2 (DHMO)
Dental Coverage Selection (select one)
 Employee Only
 Employee /Spouse
 Employee /Child(ren)
 Family
 I am **not** applying for **Dental** coverage

Vision
Vision Coverage Selection (select one)
 Employee Only
 Employee /Spouse
 Employee /Child(ren)
 Family
 I am **not** applying for **Vision** coverage

Basic Life/AD&D
 Long Term Disability
Short Term Disability Coverage Selection (select one)
 Yes
 I am not applying for **Short Term Disability** coverage

Voluntary Life Insurance
 Employee Amount \$ _____
 Spouse Amount \$ _____
 Child(ren) Amount \$ _____

SECTION 4 — COVERAGE OPTIONS

Employee/Enrollee's Name

Dependent's Name Husband Wife

DOB (Mo Day Yr) Home Address, if different — No. and Street Name City State Zip

Dependent's Name Son Daughter

DOB (Mo Day Yr) Home Address, if different — No. and Street Name City State Zip

Dependent's Name Son Daughter

DOB (Mo Day Yr) Home Address, if different — No. and Street Name City State Zip

Dependent's Name Son Daughter

DOB (Mo Day Yr) Home Address, if different — No. and Street Name City State Zip

SECTION 5 — GROUP TERM LIFE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Primary Beneficiary	DOB (Mo Day Yr) / /	Social Security Number	Relation	Benefit Percentage
Secondary Beneficiary	DOB (Mo Day Yr) / /	Social Security Number	Relation	Benefit Percentage
Contingent Beneficiary	DOB (Mo Day Yr) / /	Social Security Number	Relation	Benefit Percentage

Last Name:

Social Security Number:

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SECTION 6 — PREVIOUS COVERAGE INFORMATION

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8.

List names of every individual covered:

Form for Section 6 with fields: Name of Primary Enrollee, Date of Birth, Gender (Male/Female), Relationship to Applicant (Self/Spouse/Dependent), Group or Policy No., ID Number, Employer's Name, Employment Date, Effective Date, Will Coverage be Continued?, Expected Cancel Date, Type of Coverage (Health/Dental), Type of Policy (Self/Family/Employee/Spouse/Employee/Child).

SECTION 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health coverage when the coverage under this application becomes effective.

List names of each individual covered:

Form for Section 7 with fields: Type of Coverage (Health/Dental), Group Coverage (Yes/No), Name and Address of Other Health Care Company, Name of Policyholder, Date of Birth, Gender (Male/Female), Relationship to Applicant (Self/Spouse/Dependent), Type of Policy (Self/Two Person/Family), ID Number, Employment Date, Effective Date of Coverage, Group or Policy Number, Employer's Name.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Form for Section 8 with fields: Name of person covered, Medicare HIC# (from ID card), Medicare Part A (hospital) Start/End Dates, Medicare Part B (medical) Start/End Dates, Medicare Part D (prescription drugs) Start/End Dates, Carrier Name and Address (if BCBSTX is not the carrier).

Check reason for Medicare eligibility: Entitled age, Entitled disability, End-stage renal disease, Disability and current renal disease.

Form for Section 8 (repeated) with fields: Name of person covered, Medicare HIC# (from ID card), Medicare Part A (hospital) Start/End Dates, Medicare Part B (medical) Start/End Dates, Medicare Part D (prescription drugs) Start/End Dates, Carrier Name and Address (if BCBSTX is not the carrier).

Check reason for Medicare eligibility: Entitled age, Entitled disability, End-stage renal disease, Disability and current renal disease.

SECTION 9 — DISABLED DEPENDENT

Form for Section 9 with fields: Name of disabled dependent, Nature of disability, Has disability been diagnosed as permanent? (Yes/No), If temporary, how long is dependent expected to remain disabled?, Is dependent unable to work due to the disability? (Yes/No), If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 10 — DECLINATION OF HEALTH COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Form for Section 10 with fields: Employee, Spouse, Children, Reason for declining: Other Group Coverage, Medicare, Medicaid, Other, explain.

SECTION 11 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Fort Dearborn Life Insurance Company (FDL). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s). Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s). I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period. I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are binding upon me.

Applicant's Signature _____ Date _____