

Election Form

Complete this form and make a copy for yourself. Give the original to your employer.

IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS FORM.

A. INFORMATION ABOUT YOU

Print Your Name (First, Middle Initial, Last)

Mailing Address City State Zip Code

Home Phone () Date of Birth (MM/DD/YYYY) Social Security Number

B. YOUR ELECTION

(Check the appropriate box.)

I am not currently enrolled and I elect to....

- Enroll** in the coverage choice selected below. ❶
- Decline** this opportunity to participate.

I am currently enrolled and I elect to....

- Change** my current coverage with the choice selected below. ❶
- Change** my personal, dependent and/or beneficiary information.
- Drop** my current coverage choice.

❶ By selecting the coverage choice(s) below, I authorize my employer to deduct from my paycheck any required contributions.

Your Signature Today's Date (MM/DD/YYYY)

C. YOUR COVERAGE CHOICES

For each coverage you wish to adjust: 1) Check the appropriate box (☐) for the action you wish to make (add/drop/change to); and 2) Check the appropriate box (☐) for whom this action applies.

| MEDICAL | | (List Beneficiary and Dependents on the back of this form) | Weekly Cost |
|------------------------------------|--|--|-------------|
| <input type="checkbox"/> Add | | <input type="checkbox"/> Yourself Only | \$ 8.74 |
| <input type="checkbox"/> Drop | | <input type="checkbox"/> Yourself Plus One | \$ 19.09 |
| <input type="checkbox"/> Change To | | <input type="checkbox"/> Yourself and Family | \$ 29.72 |

QUALIFYING LIFE EVENTS

A. LOSS OF OTHER COVERAGE (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be allowed to enroll yourself and your dependents. You must submit this form, together with documentation, to your employer within 31 (* or 60) days of the LOC. If you are entitled to this special enrollment, complete **sections A & B** (above) then go to the list on the right and check the box next to your LOC, supply the date of the LOC, and finish completing the form through **section E**. When finished, make a copy of this form and give it to your employer with your documentation attached.

- Check the box of the description that identifies your **LOC**.
- Divorce*, legal separation* or death
 - Termination of employment of a dependent
 - Reduction of a dependent's hours
 - Termination of your or your dependents' COBRA rights
 - Loss of employer's contribution to spouse's or domestic partner's coverage
 - Dependent child losing eligibility as a dependent*
 - Other loss of coverage

Date of the LOC:

B. FAMILY STATUS CHANGES (FSC): Whether you are currently enrolled or previously declined coverage, you may be allowed to add, increase, decrease or drop coverage when you experience certain FSC events. You must submit this form, together with documentation, to your employer within 31 (* or 60) days of the FSC. If you are so entitled because of a recent FSC, complete **sections A & B** (above) then go to the list on the right and check the box next to your FSC, supply the date of the FSC, and finish completing this form through **section E**. When finished, make a copy of this form and give it to your employer with your documentation attached.

- Check the box of the description that identifies your **FSC**.
- Divorce*, legal separation* or death
 - Marriage
 - Birth or adoption of a dependent
 - Other

Date of the FSC:

FOR YOUR EMPLOYER'S USE ONLY

Employee ID: Hire Date (MM/DD/YYYY): Pay Type: Total Deduction: \$

Location or Site Code: Authorized Signature: Today's Date (MM/DD/YYYY):



D. BENEFICIARY INFORMATION

Print Beneficiary's Name (First, Middle Initial, Last)

Relationship

Social Security Number

E. DEPENDENT INFORMATIONCheck here if you have more dependents and provide all requested information on a separate sheet and attach it to this form.

| | | | | |
|---|---|------------------------|---------------|--|
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To | Print Dependent's Name (First, Middle Initial, Last) | Social Security Number | | |
| | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | Date of Birth | If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled? |
| | Street Address If this dependent has a different address than you, list it here: | City | State | Zip Code |



Record keeping by
Strategic Resource Company (SRC).

Insurance plan is underwritten by Aetna Life Insurance Company.

