BERING STRAIT

AK035

MERITAIN HEALTH

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM, FRONT AND BACK

EMPLOYEE NAME (LAST, FIRST, MI)				SOCIAL SECURITY NO.
SEX ❑ M ❑ F	DATE OF BIRTH (MM/DD/YY)	# OF ELIGIBLE CHILDREN	E-MAIL ADDRESS	
HOME ADDRESS			CITY	STATE
HOME TELEPHONE	WORK TELEPHONE		ZIP CODE	COUNTY
DO YOU HAVE OTHER HEALTH COVERAGE? ❑ YES ❑ NO	NAME OF OTHER INSURANCE CARRIER			EFFECTIVE DATE OF COVERAGE
MARITAL STATUS	DATE OF MARRIAGE		SPOUSE DATE OF BIRTH	SPOUSE EMPLOYED FULL-TIME? ❑ YES ❑ NO

PLAN OPTION ELECTION ❑ IMG

MEDICAL PLAN OPTION	LEVEL OF COVERAGE
❑ I DO **NOT** ELECT TO ENROLL IN THE MEDICAL PLAN.	❑ EMPLOYEE ONLY ❑ EMPLOYEE + SPOUSE ❑ EMPLOYEE + CHILD ❑ EMPLOYEE + CHILDREN ❑ FAMILY
DENTAL PLAN OPTION	**LEVEL OF COVERAGE**
❑ I DO **NOT** ELECT TO ENROLL IN THE DENTAL PLAN.	❑ EMPLOYEE ONLY ❑ EMPLOYEE + SPOUSE ❑ EMPLOYEE + CHILD ❑ EMPLOYEE + CHILDREN ❑ FAMILY
VISION PLAN OPTION	**LEVEL OF COVERAGE**
❑ I DO **NOT** ELECT TO ENROLL IN THE VISION PLAN.	❑ EMPLOYEE ONLY ❑ EMPLOYEE + SPOUSE ❑ EMPLOYEE + CHILD ❑ EMPLOYEE + CHILDREN ❑ FAMILY

EVEN IF YOU ARE DECLINING COVERAGE, YOU MUST SIGN REVERSE

LIFE INSURANCE

NAME OF PRIMARY BENEFICIARY (LAST, FIRST, MI)	RELATIONSHIP	SOCIAL SECURITY NO.
NAME OF SECONDARY BENEFICIARY (LAST, FIRST, MI) (Will receive benefits if Primary Beneficiary is deceased)	RELATIONSHIP	SOCIAL SECURITY NO.

BENEFIT ADMINISTRATOR SECTION

EFFECTIVE DATE	OCCUPATION	
FULL-TIME EMPLOY. DATE	PART-TIME EMPLOY. DATE	
DIVISION #	PPO	
PRE-TAX CONTRIB. ❑ YES ❑ NO	ANNUAL SALARY	❑ HOURLY ❑ SALARIED

❑ NEW ENROLLMENT

CONTINUOUS COVERAGE EFF. DATE

❑ SPECIAL ENROLLMENT SITUATION 📄
❑ LATE/OPEN ENROLLMENT

❑ FULL-TIME ❑ ACTIVE
❑ PART-TIME ❑ COBRA
❑ RETIRED

❑ TERMINATION

❑ VOLUNTARY ❑ EMPLOYEE
❑ INVOLUNTARY ❑ DEPENDENT

❑ ENROLLMENT CHANGE

❑ NAME ❑ STATUS CHANGE 📄
❑ ADDRESS ❑ RE-ENROLLMENT
❑ BENEFICIARY ❑ OPEN ENROLLMENT
❑ OTHER ______________________

I testify that the above information is true and correct to the best of my knowledge.

DATE

BENEFIT ADMINISTRATOR SIGNATURE

COVERED DEPENDENT INFORMATION

RELATIONSHIP TO APPLICANT	PERSONAL INFORMATION	FULL-TIME STUDENT?	DISABLED DEPENDENT?	COVERED UNDER ANOTHER PLAN?	OTHER PLAN INFORMATION
SPOUSE	NAME (LAST, FIRST, MI) / SEX DATE OF BIRTH / SOCIAL SECURITY NO.			❑ YES ❑ NO	NAME OF INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI) / SEX DATE OF BIRTH / SOCIAL SECURITY NO.	❑ YES 📄 ❑ NO	❑ YES 📄 ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI) / SEX DATE OF BIRTH / SOCIAL SECURITY NO.	❑ YES 📄 ❑ NO	❑ YES 📄 ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI) / SEX DATE OF BIRTH / SOCIAL SECURITY NO.	❑ YES 📄 ❑ NO	❑ YES 📄 ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE

📄 = **ATTACH DOCUMENTATION OR ELIGIBILITY WILL BE DELAYED**

COMPLETE REVERSE ➲

NEW PLAN ENROLLEES ONLY

Have you been covered by health insurance in the past 63 days? ❑ YES ❑ NO

If yes, please submit to your employer a copy of the Certificate of Creditable Coverage from your previous employer or insurance company. If a Certificate of Creditable Coverage is not available at the time of application, submit it as soon as it is available; without it, a delay in claims processing may occur. If you need help obtaining a Certificate of Creditable Coverage or other evidence of past coverage, please contact your employer.

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand that, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you are declining to enroll yourself or an eligible dependent for health coverage because you have (or your dependent has) existing health coverage, your employer may require that you provide a written statement indicating that you are declining coverage because of the existing health coverage. If the employer requires such a statement and notifies you of that requirement, you will receive a separate form to complete and you must complete it to preserve your right to a future special enrollment situation following a loss of that existing coverage.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE

EMPLOYEE SIGNATURE	DATE