

Please print legibly.

FOR INTERNAL USE ONLY	Administaff Client No.	Client Waiting Period	Coverage Effective Date
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INSTRUCTIONS	
You must enroll to participate	There is no <u>automatic</u> enrollment or participation in the Administaff Group Health Plan (Plan). To enroll for Plan benefits or to request an election change, complete all applicable sections of this form, read the Terms of Participation and sign and date on page 4 , and timely return the completed original form as directed.
You must enroll on time	To enroll you and provide group health and associated welfare benefits that are tied to an election of medical coverage, Administaff must receive your properly completed Benefits Enrollment/Change Request: <ul style="list-style-type: none"> • Within 30 days (or any longer period as required under state insurance law that applies to your coverage) of your becoming eligible or experiencing a mid-year election change event), <u>OR</u> • By the last day of your open enrollment period (as applicable).
Waiving coverage	If you do not submit your completed enrollment request to Administaff within 30 days* of eligibility, you automatically waive your Group Health Plan coverage and any associated welfare benefits that are tied to an election of medical coverage. If you waive Group Health Plan coverage, but basic life and personal accident insurance (PAI) coverage is available to you independent of medical coverage enrollment, you should complete Sections A & B below and Section F on page 5 of this form (Life Insurance Beneficiary Designation) and return to Administaff as directed. Certain states require individuals who waive group health plan coverage to submit a separate acknowledgment of waived benefits. You must complete and return the appropriate separate state waiver acknowledgment form if you work or live in any of the states indicated by the state-specific forms included in your Administaff employment and benefits enrollment paperwork. (See your Administaff Forms & Policies Book.)

A. Employee Information (Complete ALL fields.)

Employee Last Name		Employee First Name	Middle Name or Initial	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
Employee Street Address		City	State	Zip Code
Employee Social Security No. -	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Home Telephone No. ()	Work Telephone No. ()	Date of Birth

B. Enrollment / Change Designation

<input type="checkbox"/> ENROLLMENT Reason to Enroll: <input type="checkbox"/> New Enrollee <input type="checkbox"/> Rehire OR Reinstatement of Coverage OR Re-enrollment <input type="checkbox"/> DESIGNATE or CHANGE BENEFICIARY(IES) for Basic Term Life Insurance Complete Section F. on p. 5	<input type="checkbox"/> CHANGE Reason for Change: <input type="checkbox"/> ANNUAL OPEN ENROLLMENT <input type="checkbox"/> MID-YEAR ELECTION CHANGE IMPORTANT: You must complete Section C below to validate a mid-year election change.	Type of Change: For all types of change listed below, you must also provide the required information in Section E on p. 3, then sign and date the Terms of Participation section on p. 4 of this form. <input type="checkbox"/> ADD A DEPENDENT to your coverage <input type="checkbox"/> REMOVE A DEPENDENT from your coverage <input type="checkbox"/> CHANGE YOUR COVERAGE ELECTION <input type="checkbox"/> TERMINATE EMPLOYEE COVERAGE To end <u>ALL</u> coverage** for you and all enrolled dependents ** <u>ALL</u> coverage includes any Basic Life, PAI (AD&D) and Basic Disability insurance benefits that are included in your employee benefits package and tied to your medical coverage election. Conversion opportunity may apply; contact Administaff at 866-715-3552 for information.
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C. Mid-Year Election Change Request (This section does **NOT** apply to initial benefits enrollment or annual open enrollment.)

 Complete this section **ONLY** when requesting a mid-year change in your benefits coverage that is consistent with the election change event you check below. You must submit this change request to Administaff within **30 days*** of the election change event.

1. Please contact Administaff at **866-715-3552** to determine if documentation / proof is required.
2. Check the box below that describes the event that validates this change request.
3. Provide the name(s) of affected family member(s) in Section E (Individuals To Be Covered) on page 3 of this form.

➡ Date of the Election Change Event That Validates This Mid-Year Change Request [mm/dd/yyyy]: / /				
<input type="checkbox"/> Change in Marital Status:	<input type="checkbox"/> Marriage	<input type="checkbox"/> Legal separation	<input type="checkbox"/> Divorce or annulment	<input type="checkbox"/> Death of spouse
<input type="checkbox"/> Change in Domestic Partner Status:	<input type="checkbox"/> Add domestic partner	<input type="checkbox"/> Remove domestic partner		
<input type="checkbox"/> Change in Number of Dependents:	<input type="checkbox"/> Birth of dependent	<input type="checkbox"/> Death of dependent	<input type="checkbox"/> Adoption or placement for adoption	
<input type="checkbox"/> Change in Dependent's Eligibility under an Employer's Plan	<input type="checkbox"/> Lost eligibility	<input type="checkbox"/> Gained eligibility		
<input type="checkbox"/> Judgment, Decree or Order (QMCSO):	<input type="checkbox"/> QMCSO requiring coverage under this Plan			
<input type="checkbox"/> Change in Employment Status That Affects Eligibility:	<input type="checkbox"/> Termination of employment	<input type="checkbox"/> Change in classification: part-time / seasonal / temporary to full-time <input type="checkbox"/> Change in classification: full-time to part-time / seasonal / temporary		
<input type="checkbox"/> Change in Residence That Affects Eligibility				
<input type="checkbox"/> Entitlement to Medicare or Medicaid				
<input type="checkbox"/> Other Election Change Event Permitted by This Plan				

* Or any longer period as required under state insurance law that applies to your coverage.



D. Health Care Election(s)

To determine your health care election options, please refer to **The Benefits Book** you received in your Administaff orientation materials, ask your onsite supervisor, or call Administaff toll-free at **866-715-3552**, weekdays between 7 a.m. and 7 p.m. Central time.

Follow the instructions below to elect health care coverage for yourself and any eligible dependents you elect to cover. You (the employee) **MUST** enroll in the Administaff Group Health Plan in order to elect health care coverage for any eligible dependents. Coverage election(s) you indicate below will apply **BOTH** to you and all covered dependents. **You may not elect different coverage for your dependents.**

MEDICAL COVERAGE

To elect medical coverage under the Administaff Group Health Plan, indicate your medical coverage group election below by checking **ONLY ONE** box from the choices shown.

If the coverage group or option you elect below does NOT have an associated network available in your area, you will be enrolled in the closest corresponding coverage group or option that **is** available in your area. For information on network service areas available to you, please ask your onsite supervisor, refer to your **Benefits Book** or call Administaff at **866-715-3552**.

Administaff Medical Coverage Groups	Insurance Carrier Choices
1500 deductible / 80% coinsurance	<input type="checkbox"/> UnitedHealthcare Choice Plus 1500 <input type="checkbox"/> Tufts Health Plan CareLink Advantage PPO 1500 <i>(Available ONLY to employees who live in Massachusetts or New Hampshire)</i>
500 deductible / 90% coinsurance	<input type="checkbox"/> UnitedHealthcare Choice Plus 500 NOTE: This coverage option is <u>NOT</u> available to employees who live in Hawaii , Massachusetts or New Hampshire . <input type="checkbox"/> Tufts Health Plan CareLink Advantage PPO 500 <i>(available ONLY to employees who live in Massachusetts or New Hampshire)</i>
Varying deductible / 100% coinsurance Applicable calendar-year deductible(s) may vary from carrier to carrier.	<input type="checkbox"/> Tufts Health Plan HMO <i>(available ONLY to employees who live in Massachusetts or in limited ZIP code service areas of New Hampshire)</i> <input type="checkbox"/> PacifiCare HMO <i>(California residents only)</i> <input type="checkbox"/> Kaiser Permanente HMO <i>(California residents only)</i> <input type="checkbox"/> Blue Shield of California HMO <i>(Northern California residents only)</i>
1500 HDHP deductible / 100% coinsurance (HSA-eligible High Deductible Health Plan)	<input type="checkbox"/> UnitedHealthcare Choice Plus 1500 HDHP NOTE: This coverage option is <u>NOT</u> available to employees who live in Hawaii , Massachusetts or New Hampshire . <input type="checkbox"/> Tufts Health Plan 1500 HDHP <i>(Massachusetts and New Hampshire residents only)</i>
3000 HDHP deductible / 90% coinsurance (HSA-eligible High Deductible Health Plan)	<input type="checkbox"/> UnitedHealthcare Choice Plus 3000 HDHP NOTE: This coverage option is <u>NOT</u> available to employees who live in Hawaii , Massachusetts or New Hampshire .
Hawaii state-mandated coverage options	<input type="checkbox"/> UnitedHealthcare Options PPO <i>(Hawaii residents only)</i> <input type="checkbox"/> HMSA BlueCross BlueShield of Hawaii HMO <i>(Hawaii residents only)</i> <input type="checkbox"/> Kaiser Permanente HMO <i>(Hawaii residents only)</i>

DENTAL & VISION COVERAGE

Freedom & Independence benefits packages ONLY ▪ **Liberty benefits packages do not include Dental & Vision coverage.**

If your benefits package includes Dental & Vision coverage, it may be available to you as an **INCLUDED** benefit when you elect medical coverage above, **OR** this coverage may be available to you as a **SEPARATE** benefit election that you may elect by itself, **WITHOUT** electing medical coverage also.

Please consult your onsite supervisor or call Administaff toll-free at **866-715-3552** to determine whether your benefits package includes Dental & Vision coverage, and if so, whether your package allows you to elect Dental & Vision coverage ONLY, without being required to elect medical coverage also. Even if Dental & Vision coverage is included as part of your medical coverage, you should still complete this section of the form by indicating your Dental & Vision coverage election below.

☐ I elect Dental & Vision coverage, **in addition to the medical coverage option I have elected above.**
Be sure **also** to check a medical coverage group or option from the choices in the Medical Coverage section above.

☐ I elect Dental & Vision coverage **ONLY**, if allowed by my Administaff benefits package.

IMPORTANT: IF Dental & Vision coverage is available to you as a **SEPARATE** election from medical coverage, and you elect **ONLY** Dental & Vision coverage, **you will be considered to have waived enrollment for medical coverage under the Administaff Group Health Plan, as well as enrollment for certain welfare benefits that may be included in your benefits package and tied to an election of medical coverage** (such as basic term life & PAI /AD&D).

E. Individuals To Be Covered (Not required if you are waiving all Plan coverage.)

It is your responsibility and obligation to ensure that all applicable eligibility requirements are satisfied before you enroll a person as your eligible dependent. In addition, if an enrolled dependent loses eligibility under the Plan, you must notify Administaff of such change as soon as possible. Refer to the Administaff Group Health Plan Summary Plan Description (SPD) for the rules that apply.

INSTRUCTIONS FOR COMPLETING DEPENDENT INFORMATION: A Social Security number is **REQUIRED** for every individual you wish to cover under the Administaff Group Health Plan. **ENROLLMENT WILL BE DELAYED** for any dependents for whom you do **not** provide a Social Security number on this form until their Social Security number(s) are provided. **If you do not provide missing dependent Social Security numbers within your designated enrollment period, then those dependents will NOT be covered, and you will have to wait until the next open enrollment period to enroll them. Exceptions:** Non-U.S. citizens that are not required to have a Social Security number (please identify below), and newborns under the age of one year. If you cannot provide a Social Security number for a newborn at this time, you should provide it to Administaff as soon as you obtain it in the future.

NOTE: Common-law marriage may be formed in only a minority of states. State law marriage requirements generally determine whether a person may be enrolled as your common-law spouse.

<input type="checkbox"/> I elect coverage for my eligible dependents. Provide requested information below for EMPLOYEE and ALL DEPENDENTS to be covered. <div style="text-align: center;"> </div> <input type="checkbox"/> I have attached a separate sheet to list additional dependents, using the format below.	<input type="checkbox"/> I decline coverage for my dependents. <input type="checkbox"/> I do not have any eligible dependents to enroll at this time.	IF YOU ELECT AN <u>HMO</u> COVERAGE OPTION: Designation of a Primary Care Physician (PCP) is required for all HMO participants. <i>Refer to the insurance carrier's Directory of Providers for in-network provider names & ID numbers</i>
EMPLOYEE INFORMATION:		Primary Care Physician Designate a Primary Care Physician (PCP) for yourself and each dependent listed.
<input type="checkbox"/> Add <input type="checkbox"/> Remove		OB/GYN Provider Contact Administaff to see if your coverage option permits female members to select an OB/GYN provider in addition to a PCP.
Employee Name (First, Middle Initial, Last) _____ Social Security # REQUIRED: _____		Primary Care Physician Name _____ ID No. (Required) _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth REQUIRED: ____/____/____ Relation Code E		OB/GYN Physician Name _____ ID No. (Required) _____
DEPENDENT INFORMATION:		
A Relationship Code is required for each dependent. Please use the following Relationship Codes for any dependents listed below: S = Spouse (Use this code to indicate <i>ONLY</i> a person who is treated as an eligible employee's lawful spouse under <u>federal</u> law (including a common-law spouse). C = Child P = Domestic Partner If a dependent has no Social Security Number yet, leave blank.		IF YOU ELECT AN <u>HMO</u> COVERAGE OPTION: Designation of a Primary Care Physician (PCP) is required for all HMO participants. <i>Refer to the insurance carrier's Directory of Providers for in-network provider names & ID numbers</i>
<input type="checkbox"/> Add <input type="checkbox"/> Remove		Primary Care Physician Name _____ ID No. (Required) _____
Dependent Name (First, Middle Initial, Last) _____ Social Security # REQUIRED: _____		OB/GYN Physician Name _____ ID No. (Required) _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth REQUIRED: ____/____/____ Relation Code _____		Primary Care Physician Name _____ ID No. (Required) _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove		OB/GYN Physician Name _____ ID No. (Required) _____
Dependent Name (First, Middle Initial, Last) _____ Social Security # REQUIRED: _____		Primary Care Physician Name _____ ID No. (Required) _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth REQUIRED: ____/____/____ Relation Code _____		OB/GYN Physician Name _____ ID No. (Required) _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove		Primary Care Physician Name _____ ID No. (Required) _____
Dependent Name (First, Middle Initial, Last) _____ Social Security # REQUIRED: _____		OB/GYN Physician Name _____ ID No. (Required) _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth REQUIRED: ____/____/____ Relation Code _____		Primary Care Physician Name _____ ID No. (Required) _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove		OB/GYN Physician Name _____ ID No. (Required) _____
Dependent Name (First, Middle Initial, Last) _____ Social Security # REQUIRED: _____		Primary Care Physician Name _____ ID No. (Required) _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth REQUIRED: ____/____/____ Relation Code _____		OB/GYN Physician Name _____ ID No. (Required) _____

Please identify below by name ANY dependent to be covered who is:

- A non-U.S. citizen that is not required to have a Social Security number, **OR**
- 19 years of age or older (unless otherwise required by a state law that applies to your coverage) and a full-time student, or incapacitated and financially dependent

NOTE: Verification of dependent status may be required as determined by your insurance carrier.

Dependent Name: _____	<input type="checkbox"/> Non-U.S. Citizen	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Incapacitated Adult
Dependent Name: _____	<input type="checkbox"/> Non-U.S. Citizen	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Incapacitated Adult
Dependent Name: _____	<input type="checkbox"/> Non-U.S. Citizen	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Incapacitated Adult

Terms of Participation

By my signature (below) to these Terms of Participation, I request the Group Health Plan (Plan) coverage for which I am eligible and have elected on this form. I agree to pay any required contributions pursuant to the terms of the Plan. I also authorize all applicable reductions from my compensation in payment of any required contributions. I understand that any material misstatements, misrepresentations or omissions on this form (including with respect to my or my dependents' eligibility) may result in any Plan coverage being void as of its effective date with no benefits payable. I also understand that the failure to notify Administaff of an enrolled dependent's loss of eligibility may result in the termination of Plan coverage as of the date of such loss with no benefits payable.

I understand that all coverage elected pursuant to this form (including coverage under the medical coverage option I have selected in Section D, if any) will be governed by the terms of the Plan. I further understand that if I have selected **only** the Dental & Vision coverage option in Section D, I am waiving enrollment for medical coverage under the Plan. By waiving medical coverage, I may also be waiving enrollment for certain insurance benefits under the Administaff Welfare Benefits Plan that are included in my benefits package and tied to my medical coverage election, such as basic term life, PAI (AD&D) and basic disability coverage. I further understand that, if I elect medical coverage and subsequently decide to drop such coverage, I may similarly lose any Welfare Plan benefits that are included in my benefits package and tied to my medical coverage election.

I understand that the reduction in my compensation authorized pursuant to these Terms of Participation will be in addition to any reductions under other agreements or benefits plans. I understand that I cannot change or revoke my Plan enrollment election until the next open enrollment period, unless a mid-year election change event occurs that lets me cancel or change my election mid-year. If eligible, I elect to participate in the Administaff Cafeteria Plan and authorize Administaff to reduce my compensation on a pre-tax basis by an amount equal to my required contribution for coverage under the Plan. I understand that my election is void and I will not be a participant in the Administaff Cafeteria Plan if the Plan Administrator determines that I do not satisfy the eligibility rules of the Administaff Cafeteria Plan as of the date my election would have been effective, and Administaff may withhold from compensation any tax amounts owed for contributions made while ineligible. The Plan Administrator (in its discretion and with or without my consent) may deem taxable any or all of my contribution election at any time to the extent it deems appropriate for compliance with applicable law or the terms of the Administaff Cafeteria Plan.

I understand that the amount of my required contribution for coverage (and corresponding compensation reduction) is subject to change, and that the Plan Administrator for this Plan (and the Administaff Cafeteria Plan, if applicable) may change or cancel the amount of my compensation reduction in accordance with the terms of the Plan (and the Administaff Cafeteria Plan, if applicable), in its sole discretion and to the extent it deems appropriate for compliance with applicable law or the terms of such plan(s). My signature (below) to these Terms of Participation affirms that all information and statements provided on this form (including with respect to my or my dependents' eligibility) are accurate and complete to the best of my knowledge and belief.

**SIGN
& DATE
THE
FORM**

By signing, I acknowledge that I have read and understand all sections on all pages of this form and agree to all Terms of Participation. I further understand that Plan coverage is subject to all terms of the Plan, including applicable insurance policies and similar arrangements.

Employee Signature

Print Employee Name

Date Signed

State-Required Acknowledgments of Waived Health Benefits

If you waive coverage under the Administaff Group Health Plan and you live or work in one of the states that require a separate, state-specific acknowledgment of waived benefits, Administaff must receive your completed state-specific waiver acknowledgment form. You can find the required separate state-specific waiver acknowledgment form(s) in your Administaff employment and benefits enrollment paperwork. (See your Administaff Forms / Policies Book.)

Kaiser Foundation Health Plan Arbitration Agreement

NOTE: If you elect coverage in the Kaiser Permanente HMO plan, you must read, sign and date this Arbitration Agreement.

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee/Subscriber Signature

Date Signed

Georgia Residents Only — Please Read and Sign Below

I hereby acknowledge that I have been informed of the following prior to my enrollment: (i) number, mix and location of participating / network health care providers; (ii) limitations of choices of participating / network health care providers; and (iii) disclosure of contractual relationship between participating / network provider and the insurer.

Employee Signature

Date Signed

Keep a copy of your completed enrollment form for your records.

Fax or mail pages 1-5 of the original of your completed Benefits Enrollment/Change Request to your Administaff payroll specialist.

F. Basic Life Insurance Beneficiary Designation

If you meet eligibility requirements, and are actively at work on your coverage effective date, you may be covered under the Administaff Basic Life Insurance/ Accidental Death & Dismemberment (AD&D) policy. To designate a beneficiary or beneficiaries, or to change or update a previously submitted designation, review the Guidelines for Designation of Beneficiaries below and complete the information requested.

Guidelines for Designation of Beneficiaries

- **Primary Beneficiaries.** Unless you designate a percentage, proceeds are paid to surviving primary beneficiaries in equal shares.
- **Contingent Beneficiaries.** Proceeds are paid to contingent beneficiaries only if there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, any proceeds paid to contingent beneficiaries will be paid to the surviving contingent beneficiaries in equal shares.
- If you do provide percentages, the total percentage in each category (primary or contingent) must equal 100%.
- Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).
- If no beneficiary is designated or there are no surviving primary or contingent beneficiaries, policy rules will govern payment of proceeds. However, if a previous designation has been made, you must provide a new designation of beneficiary in order to revoke the prior designation.
- Your beneficiary designation(s) will also apply in instances where an accident covered by the Administaff Basic AD&D policy results in death. (For covered accidents not resulting in death, the covered employee is the beneficiary of any proceeds paid by the AD&D policy.)
- Use given names, not initials. Example: Mary R. Smith, not M.R. Smith or Mrs. John Smith.
- **Trust as Beneficiary.** You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]." If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.
- **Designation of Minors.** While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.
- **Life Status Changes.** You should review your beneficiary designation when significant life status events occur, such as marriage, divorce or birth of a child.
- **Community Property Laws.** If you are married and live in a community property state, and you name someone other than your spouse as beneficiary, the payment of benefits could be delayed or disputed unless your spouse also signs the beneficiary designation.
Community property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, Wisconsin.
- **See an attorney.** These guidelines are general, and are not intended to be relied upon as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous and meets legal requirements.
- You should review your beneficiary designation(s) annually, and submit revised designations or updated information as necessary.

Employee Last Name	Employee First Name	Middle Name or Initial	Employee Social Security Number
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Basic Life and Basic Accidental Death & Dismemberment, Life Insurance Company of North America Policy Number FLX-051416

EMPLOYEE'S PRIMARY BENEFICIARY(IES)	ADDRESS	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO. OR TAX ID	PERCENTAGE (Total Must = 100%)
CONTINGENT BENEFICIARY(IES)	ADDRESS	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO. OR TAX ID	PERCENTAGE (Total Must = 100%)

☐ I have attached a separate sheet to list additional beneficiaries, using the format above.

[If you need to attach a separate sheet, be sure it includes your printed full name and last 4 digits of your Social Security number. Sign and date the additional sheet.]

Employee Signature (This signature attests ONLY to Basic Life Insurance Beneficiary Designation)	Date Signed
Spouse Signature (May be required if you live in a community property state. See Guidelines above.)	Date Signed

Questions? Call Administaff toll-free at **866-715-3552** (weekdays from 7 a.m. to 7 p.m. Central time).

The Administaff Group Health Plan's (Plan's) Summary Plan Description (SPD), the benefit materials prepared by the insurer for your coverage option and your Administaff enrollment materials describe the benefits available under the Plan for enrollees in that coverage option and also explain some special rules for obtaining benefits. For each coverage option, the Plan pays only the benefits it has contracted with the insurer to provide. You are encouraged to contact your insurer if information in the Plan's SPD or the insurer's materials does not answer your questions. Once you are enrolled, further information is available online on Administaff's Employee Service Center, including access to your insurer's Web site.

Insurance Policies. Administaff provides life, disability, medical, vision and dental benefits through group insurance policies. Administaff does not self-fund these benefits.

Pre-Existing Conditions. The Plan does not pay expenses for the treatment of a pre-existing condition during an individual's limitation period. A pre-existing condition generally means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within a specified look-back period (as defined under your coverage option) before your coverage eligibility date or, if applicable, before the first day of your waiting period. If a pre-existing condition limitation applies in your situation, no coverage is provided for expenses related to a pre-existing condition for a 12-month limitation period (or any shorter limitation period defined under your coverage option). (See the Coverage Options booklet that is provided to all new employees with the Benefits Booklet to learn the look-back period and limitation that applies to your coverage option).

Your pre-existing condition limitation period may be eliminated or shortened one day for each day that you had prior creditable coverage under another health plan, provided there was not a lapse in coverage of 63 days or more. (A waiting period for plan eligibility is not counted as time associated with a lapse of coverage.) Most group health plans must provide a certificate of prior creditable coverage when a person's coverage terminates. If necessary, contact Administaff at the toll-free number below for help in obtaining a certificate of prior creditable coverage from a prior plan or other help in showing that you had creditable coverage.

The pre-existing condition limitation will not apply to:

- (i) **genetic information** (unless a condition related to that information is diagnosed)
- (ii) **pregnancy, or**
- (iii) **a condition of a newborn** (or adopted child) **who became covered within 30 days* of birth** (or adoption or placement for adoption).

* Or any longer period as required under state insurance law that applies to your coverage. The special enrollment period related to Medicaid and SCHIP is 60 days.

Enrollment and Special Enrollment. You and your eligible dependents may become enrolled in the Plan only during certain designated enrollment periods. As a newly eligible employee, you may first enroll for coverage (including coverage for your eligible dependents) during the 30-day* period following the date you become eligible. This 30-day period is called your initial enrollment period. In addition, as an eligible employee you may enroll for coverage during your annual open enrollment period. Administaff will tell you when your annual open enrollment period occurs. Outside of your initial enrollment period or open enrollment period, you may enroll for coverage only if a special enrollment event or other mid-year election change event (described below under "Changing Your Coverage") occurs.

A special enrollment event may occur if you decline Plan coverage for yourself or your eligible dependent(s) because of other health insurance coverage and that coverage is later lost (or the other plan sponsor stops contributing to, or otherwise terminates, that coverage). A special enrollment event may also occur if you or your eligible dependent(s) loses Medicaid or State Children's Health Insurance Program (SCHIP) coverage, or becomes eligible for a premium assistance subsidy for such coverage.*

In addition, a special enrollment event may occur if you obtain a new eligible dependent as a result of marriage, birth, adoption or placement for adoption. Refer to this Plan's SPD for more details about special enrollment events. If a special enrollment event occurs, you and your affected eligible dependents may become enrolled in the Plan if you request enrollment during the 30-day* period following the date of the special enrollment event.

Changing Your Coverage. Once enrolled, your Plan enrollment election will usually continue for the remainder of your coverage period unless you cancel or change your election. You can cancel or change your Plan enrollment election only during your open enrollment period or if you experience a mid-year election change event. The election change rules under this Plan and the Administaff Cafeteria Plan determine whether you have experienced a mid-year election change event (examples include marriage, divorce, death of a dependent, certain changes in employment status and certain cost and coverage change situations). If you experience a mid-year election change event, your election change must be consistent with that event and must be made within 30 days* of the event. The Plan Administrator for this Plan (and the Administaff Cafeteria Plan, if applicable) determines in its sole discretion whether your mid-year election change request is permitted. Refer to this Plan's SPD for a summary of the events that may enable you to change your Plan enrollment election mid-year and additional rules that apply.

Women's Health and Cancer Rights Act Benefits. As required by the Women's Health and Cancer Rights Act of 1998, Plan benefits are payable for covered expenses incurred by a person covered under the Plan for mastectomy-related services in a manner determined in consultation with the attending physician and patient for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema. These benefits are subject to the Plan's regular co-payments and deductibles.

To Return Your Completed Enrollment Form

1. **MAKE A PHOTOCOPY** to keep for your records of all six pages of the form. (If provided on three pages, be sure to copy **both** sides of each page.)
2. For fastest receipt and processing by Administaff, **FAX pages 1- 5** of your photocopy of the form to your Administaff payroll specialist.
3. If you prefer, you may **mail the original of your completed form** to your Administaff payroll specialist.
4. **FIND YOUR PAYROLL SPECIALIST'S address, fax and telephone numbers** in your enrollment materials, or online via the Employee Service Center (www.administaffservices.com).

Administaff must receive a completed enrollment form within 30 days of your eligibility to enroll (or any longer period as required under state insurance law that applies to your coverage). If you fail to submit your completed enrollment form to Administaff within 30 days of eligibility, you automatically waive your Group Health Plan coverage and any associated welfare benefits.

Allow two weeks from the date Administaff receives your completed Benefits Enrollment form for your application to be processed by Administaff and your insurance carrier. It can then take up to four weeks for your insurance carrier to mail your membership ID card(s) to your home address. During this processing period, you may have to pay out-of-pocket for medical and prescription expenses you incur, then file a claim for reimbursement. Claim forms are available online in the Forms Toolbox of the Employee Service Center at www.administaffservices.com.

Benefits Questions? Call Administaff toll-free (weekdays 7 a.m.–7 p.m. CT) at **866-715-3552**