

GROUP NO. [] EMPLOYEE LAST NAME [] EMPLOYEE FIRST NAME []

Section 4 - Dependent Information - Please provide all information for each person to be covered. Consult employer guidelines for dependent eligibility.

SPOUSE LAST NAME [] SPOUSE FIRST NAME [] MI [] JR., SR., ETC. [] DATE OF BIRTH [] Male [] Female [] SOCIAL SECURITY NO.** []

HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? [] YES [] NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: [] To: []

(1) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] DATE OF BIRTH [] Male [] Female [] SOCIAL SECURITY NO.** []

[] Natural Child/Stepchild [] Adopted/Legal Guardian [] Other (specify) [] [] Physically Handicapped [] Full-time Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? [] YES [] NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: [] To: []

(2) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] DATE OF BIRTH [] Male [] Female [] SOCIAL SECURITY NO.** []

[] Natural Child/Stepchild [] Adopted/Legal Guardian [] Other (specify) [] [] Physically Handicapped [] Full-time Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? [] YES [] NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: [] To: []

(3) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] DATE OF BIRTH [] Male [] Female [] SOCIAL SECURITY NO.** []

[] Natural Child/Stepchild [] Adopted/Legal Guardian [] Other (specify) [] [] Physically Handicapped [] Full-time Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? [] YES [] NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: [] To: []

Section 5 - Ancillary Insurance Information (NOTE: Products are offered by USAbLe Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)

ELECT (Mark all that apply): [] Basic Life/ADD [] Dependent Life [] STD [] LTD [] Supplemental Life/ADD Life Class [] Annual Salary \$ [] .00

Table with columns: BASIC LIFE INSURANCE AMT, SUPPLEMENTAL LIFE/ADD AMT, BENEFICIARY, RELATIONSHIP, PERCENTAGE. Includes values like \$.00 and 1, 2, 3, 4.

Section 6 - Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional, separate waiver form.

DECLINE COVERAGE - I understand that I have been offered, and have declined, coverage sponsored by my employer. Medical [] Dental [] Vision [] Basic Life/ADD [] Dependent Life [] STD [] LTD [] Supplemental Life/ADD [] Reason for declining (Mark all that apply): [] Other Group Medical Coverage [] Other Group Dental Coverage [] Other Group Vision Coverage [] I have TennCare [] Other []

GROUP NO. [] GROUP NAME []

EMPLOYEE LAST NAME [] EMPLOYEE FIRST NAME [] EMPLOYEE DATE OF BIRTH [] WAIVER SIGNATURE (Note: Signature also required in Section 3 when electing any coverage) [] DATE []

Special Enrollment Period for Medical, Dental and Vision: An Employee or eligible dependent who did not apply for coverage within thirty-one (31) days of first becoming eligible for coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time coverage under this Plan was previously offered, that such other coverage was the reason for declining coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee also may enroll at the next Open Enrollment Period.