WATKINS ASSOCIATED INDUSTRIES, INC.

Group Health Plan Enrollment & Election Change Form

A

Social Security Number	Last Name	First Name, MI	Maiden Name	Co.	Loc.

Date of Birth	Home Street Address	Apt. #	City	State	Zip

Home Telephone Number	Work Telephone Number	Legal Marital Status - Check one (Common law check single):
		❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Other

B

Enrollment

- ❒ New Hire
- ❒ Rehire
- ❒ Late Enrollment
- ❒ Special Enrollment

Changes I

(Requires Reason for Election)

- ❒ Add dependent
- ❒ Drop dependent
- ❒ Terminate all coverage

Changes II

(Does not require Reason for Election)

- ❒ Information update only
- ❒ Other

Reason for Election

❒ Annual Plan Election for January 1, ____________ (Please enter year)

❒ Life Event - Please check one event and provide date: ____________

- ❒ Legal marital status change
- ❒ Birth/Adoption
- ❒ Death
- ❒ Employment status change (self/spouse/dependent)
- ❒ Change in eligibility (unmarried dependents)
- ❒ Significant change in health coverage directly attributed to employment (self/spouse/dependent)

C

Request for Coverage

Circle One:	Rela-tion	Name (Last, First, MI) & Address if DIFFERENT from participant	Social Security Number	Date of Birth	M or F	✦ Handi-capped? Y/N	✦ Student? Y/N	Other Health Plans? Y/N	Medi-care/-caid? Y/N	Claim Dep on tax return? Y/N
Add Drop Change	Self		Same as above	Same as above						
Add Drop Change										
Add Drop Change										
Add Drop Change										
Add Drop Change										
Add Drop Change										

✦ Proof of disability or attendance at an accredited education institution must be provided for eligible dependents age 19 and over.

D

Acknowledgment - signature required

❒ I elect coverage for myself and my dependents. ❒ I elect to make only the changes listed in Section C.

❒ I elect coverage for myself only: ❒ I refuse coverage for my eligible spouse/dependents. ❒ I don't have any eligible spouse/dependents.

❒ I decline coverage: ❒ I have other health coverage. ❒ I do NOT have other health coverage.

I have read and agree to the terms of the authorization on the back of this form. I understand that, in the event I fail to sign this form within 30 days of a Life Event, eligibility for this plan may be affected.

Employee Signature: ______________________________________ Date: ______________

E

For Watkins use only				For Payroll use only
Company Code	Company Name		Hire Date	
Location/Dept. Code	Company Location	HR/BEN Date & Initials	Effective Date	PR Date & Initials

White – WEB | Pink – Payroll | Green – HR/Benefits | Goldenrod – Employee

Group Health Plan Information

Pre-Existing Plan Limitation:

This limitation may result in the denial of benefits for certain claims.

The exclusion states:

Any physical, mental or dental condition, regardless of the cause of the condition, for which medical or dental advice, diagnosis, care, or treatment was recommended or receive within the six-month period prior to your most recent benefit enrollment date will be a pre-existing condition. A diagnosis is not required for a pre-existing condition to exist.

Pre-Existing limit reduction:

This pre-existing limitation may be reduced if you have a "Certificate of Creditable Coverage" from your previous employer(s) detailing your health coverage during the past 18 months.

What will I receive after I enroll?

Shortly after your coverage becomes effective WEB will send you a Summary Plan Description (SPD) for the plan, a Group Health ID and Prescription card and a claim form along with a return envelope.

What if I need health care, but I don't have my card?

If you need medical, prescription, vision or dental services call WEB at 1-800-333-3841 for assistance.

Acknowledgement

I elect to be covered for the benefits to which I may become entitled under the Group Health Plan indicated. I authorize the company to deduct from my plan, or where applicable, to defer cash compensation otherwise payable to me, in order to fulfill my elections above or cost of necessary further dependent coverage. ***I acknowledge that the Group Health Plan election made is irrevocable for the plan year except for a major life event*** such as marriage, divorce, death or birth of a child, etc, after which I have 30 days in which to change my election. My signature on the front of this form affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

Watkins Associated Industries, Inc.
Group Health Plan Enrollment & Election Change Form

What is this form for?

To enroll in the group health plan, Open Choice Preferred Provider Organization (PPO) and Indemnity Plan.

What is the Group Health Plan?

This plan includes medical, prescription, dental and vision benefits for you and your eligible dependents. Please refer to the Summary Plan Description (SPD) for specific benefit information for each plan. Your local Human Resources (HR) representative or your companies Benefits Department (BD) representative has a reference copy of the SPD and current premium rates for your area. They can also answer questions about this form.

When should I complete this form? When will it become effective?

- Fill out this form during your waiting period. Ask your local HR or BD representative for the duration of your waiting period. Your participation start date will be the day after your waiting period has been satisfied.
- Fill out this form within 30 days of a life event to change your plan elections. Life events include change in 1) legal marital status, 2) number of dependents, 3) your spouse or your dependents' employment status, work schedule, residence or worksite and 4) in cases where your dependent satisfies or ceases to satisfy the eligibility requirement for unmarried dependents. It is your responsibility to notify HR or BD of a change in dependent eligibility within 30 days of the life event; failure to do so may result in loss of coverage availability. The change must correspond to the life event. Contact your HR or BD representative for the effective date.
- Fill out this form if you are making a plan election change for any reason other than a life event. Contact your HR or BD representative for the effective date.
- Fill out this form during the annual election period to change your plan elections. Your participation change date will be January 1 following the annual election period. **If you want to maintain your current plan elections, you do NOT have to complete this form.**

What are the required attachments?

- Your former employer(s) should have given you, if applicable, a "certificate of creditable coverage" detailing your health coverage during the past 18 months. In order to avoid unnecessary pre-existing condition limitations, attach the certificate(s) to your application.
- For eligible dependents age 19 and over, please provide proof of disability or attendance at an accredited education institution as applicable. ***(Student status must be submitted every quarter or semester except summer. Handicap status must be submitted once each year.)***
- If you are adding a dependent, you must attach the supporting document, eg. a birth, adoption notice or certificate, or marriage certificate. When your newborn or adopted child receives a social security number, you need to send your HR or BD a copy of the social security card.

Where should I send the completed form?

Give your completed form and required attachments to your local HR or BD representative. Keep this cover sheet and the goldenrod copy for your records.

How do I complete this form?

For section-by-section help in completing this form, refer to the other side of this cover sheet.

What should I do if I do not want to enroll my dependents or me in the group health plan?

Complete this form and check the box in Section D stating 'I Decline Coverage'. Completion of this form may entitle you and your dependents to special enrollment privileges if you later lost your other coverage and need to enroll in this plan.

✍ Use a ball-point pen and press firmly. ✍

Watkins Associated Industries, Inc.
Group Health Plan Enrollment & Change Form Instructionss

HELP Section-by-section instructions:

A. Employee Information Section

Please complete all requested information.

B. Enrollment / Changes I & II / Reason for Election

- New Hire if you are enrolling during your waiting period following your full-time start date.
- Rehire if applicable
- Late enrollment if you are enrolling after your waiting period. You must also check the applicable box in the Life Event Change Reason box.
- Special enrollment if you previously signed a "Group Health Plan Coverage Declaration" form and have lost your other coverage because the coverage period ran out, the other plan is terminated or you or your dependents lost eligibility under the other plan. You must also check a box in the Life Event Change Reason box if you are changing your elections or number of dependents covered.

Changes I & II boxes

Check the reason you are requesting a change. You must also check a box in the Life Event Change Reason box if you are adding or dropping a dependent.

Reason for Election box

Please check the applicable box.

Life Event Date

The date your family status changed, for example: marriage date.

C. Request for Coverage

Individuals Covered.

In the first box, circle 'Add' to add a dependent, 'Change' to change information about a dependent, or 'Drop' to drop a dependent.

In the relation box write 'W' for wife, 'H' for husband, 'S' for son, 'D' for daughter, 'Y' for step-son and 'X' for step-daughter. If the dependent is not a biological or legally adopted child, please write child's relationship to you.

Complete the rest of the information on each line for each dependent covered including yourself. Mark YES if the dependent is over age 19, handicapped, full time student, there is another health plan, or if Medicare of Medicaid applies to that dependent.

D. Acknowledgment - Signature Required

Carefully read this box and the information on the back of the enrollment form then sign and date the form. We cannot process the form without your signature.

Do not complete any information boxes below your signature line.

✍ Use a ball-point pen and press firmly. ✍