

**Form I-9, Employment  
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** (To be completed and signed by employee at the time employment begins.)

|                                  |       |                |                                |
|----------------------------------|-------|----------------|--------------------------------|
| Print Name: Last                 | First | Middle Initial | Maiden Name                    |
| Address (Street Name and Number) |       | Apt. #         | Date of Birth (month/day/year) |
| City                             | State | Zip Code       | Social Security #              |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) \_\_\_\_\_
- An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

|                      |                       |
|----------------------|-----------------------|
| Employee's Signature | Date (month/day/year) |
|----------------------|-----------------------|

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

|                                                         |            |
|---------------------------------------------------------|------------|
| Preparer's/Translator's Signature                       | Print Name |
| Address (Street Name and Number, City, State, Zip Code) |            |
| Date (month/day/year)                                   |            |

**Section 2. Employer Review and Verification** (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

| List A                          | OR | List B | AND | List C |
|---------------------------------|----|--------|-----|--------|
| Document title: _____           |    | _____  |     | _____  |
| Issuing authority: _____        |    | _____  |     | _____  |
| Document #: _____               |    | _____  |     | _____  |
| Expiration Date (if any): _____ |    | _____  |     | _____  |
| Document #: _____               |    | _____  |     | _____  |
| Expiration Date (if any): _____ |    | _____  |     | _____  |

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

|                                                                                           |            |                       |
|-------------------------------------------------------------------------------------------|------------|-----------------------|
| Signature of Employer or Authorized Representative                                        | Print Name | Title                 |
| Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) |            | Date (month/day/year) |

**Section 3. Updating and Reverification** (To be completed and signed by employer.)

|                             |                                                    |
|-----------------------------|----------------------------------------------------|
| A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable) |
|-----------------------------|----------------------------------------------------|

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

|                       |                   |                                 |
|-----------------------|-------------------|---------------------------------|
| Document Title: _____ | Document #: _____ | Expiration Date (if any): _____ |
|-----------------------|-------------------|---------------------------------|

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

|                                                    |                       |
|----------------------------------------------------|-----------------------|
| Signature of Employer or Authorized Representative | Date (month/day/year) |
|----------------------------------------------------|-----------------------|

# Form W-4 (2012)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** The IRS has created a page on [www.irs.gov/w4](http://www.irs.gov/w4) for information about Form W-4, at [www.irs.gov/w4](http://www.irs.gov/w4). Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for yourself if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if: } **B** \_\_\_\_\_

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

**C** Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit . . . . **F** \_\_\_\_\_

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G** **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children.
- If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child . . . . **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► **H** \_\_\_\_\_

For accuracy, complete all worksheets that apply. }

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Form W-4</b><br/>Department of the Treasury<br/>Internal Revenue Service</p>                                                                                                                                                                                                                                                                                                                                                                                                                            | <h2>Employee's Withholding Allowance Certificate</h2> <p>► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | <p>OMB No. 1545-0074</p> <h1 style="font-size: 2em;">2012</h1>                                                                                                                                                                                                |
| <p><b>1</b> Your first name and middle initial _____ Last name _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                      | <p><b>2</b> Your social security number _____</p>                                                                                                                                                                                                             |
| <p>Home address (number and street or rural route) _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      | <p><b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br/>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</p> |
| <p>City or town, state, and ZIP code _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                      | <p><b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/></p>                                                                           |
| <p><b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) _____</p>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                      | <p><b>5</b> _____</p>                                                                                                                                                                                                                                         |
| <p><b>6</b> Additional amount, if any, you want withheld from each paycheck . . . . .</p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                      | <p><b>6</b> \$ _____</p>                                                                                                                                                                                                                                      |
| <p><b>7</b> I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption.</p> <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> <p>If you meet both conditions, write "Exempt" here . . . . . ► <b>7</b> _____</p> |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                               |
| <p>Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.</p>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                               |
| <p><b>Employee's signature</b><br/>(This form is not valid unless you sign it.) ► _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                      | <p><b>Date</b> ► _____</p>                                                                                                                                                                                                                                    |
| <p><b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) _____</p>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                      | <p><b>9</b> Office code (optional) _____ <b>10</b> Employer identification number (EIN) _____</p>                                                                                                                                                             |

# Employee's Withholding Allowance Certificate

North Carolina Department of Revenue

|                                                            |       |                                                                                                                            |                                   |
|------------------------------------------------------------|-------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Social Security Number                                     |       | Marital Status                                                                                                             |                                   |
| _____                                                      |       | <input type="radio"/> Single <input type="radio"/> Head of Household <input type="radio"/> Married or Qualifying Widow(er) |                                   |
| First Name (USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS) |       | M.I.                                                                                                                       | Last Name                         |
| _____                                                      |       | _____                                                                                                                      | _____                             |
| Address                                                    |       |                                                                                                                            | County (Enter first five letters) |
| _____                                                      |       |                                                                                                                            | _____                             |
| City                                                       | State | Zip Code (5 Digit)                                                                                                         | Country (If not U.S.)             |
| _____                                                      | _____ | _____                                                                                                                      | _____                             |

(See Form NC-4 Instructions before completing this form)



|                                                                                                                                                                                                                                                                                                                                                          |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1. Total number of allowances you are claiming<br>(From Line F of the Personal Allowances Worksheet on Page 2)                                                                                                                                                                                                                                           | _____                               |
| 2. Additional amount, if any, you want withheld from each pay period<br>(Enter whole dollars)                                                                                                                                                                                                                                                            | _____ .00                           |
| 3. I certify that I am not subject to North Carolina withholding because I meet the following two conditions:<br>• Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; and<br>• This year I expect a refund of all State income tax withheld because I expect to have no tax liability.                | <input type="checkbox"/> Check Here |
| 4. I certify that I am not subject to North Carolina withholding because I meet the requirements of the Military Spouses Residency Relief Act and I am legally domiciled in the state of _____<br>(Enter state of domicile)                                                                                                                              | <input type="checkbox"/> Check Here |
| If line 3 or line 4 above applies to you, enter the year effective <u>20</u> and write "EXEMPT" here → _____                                                                                                                                                                                                                                             |                                     |
| 5. I certify that I no longer meet the requirements for exemption on line 3 <input type="checkbox"/> or line 4 <input type="checkbox"/> (Check applicable box)<br>Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on line 1 and any amount entered on line 2. | <input type="checkbox"/> Check Here |

**CAUTION:** If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

|                                                                                                                                                                                                                                                             |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Employee's Signature _____                                                                                                                                                                                                                                  | Date _____ |
| I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or 4, whichever applies. |            |

(Employer: Complete below only if sending to the North Carolina Department of Revenue. Submit the original and keep a copy for your records.)

|                                       |                                   |                    |                       |
|---------------------------------------|-----------------------------------|--------------------|-----------------------|
| Employer's Name (USE CAPITAL LETTERS) | FEIN                              |                    |                       |
| _____                                 | _____                             |                    |                       |
| Employer's Address                    | County (Enter first five letters) |                    |                       |
| _____                                 | _____                             |                    |                       |
| City                                  | State                             | Zip Code (5 Digit) | Country (If not U.S.) |
| _____                                 | _____                             | _____              | _____                 |

### Authorization for Direct Deposits - Employee Form

This authorizes \_\_\_\_\_ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

**NOTE:** Enter your company name in the blank space above.

**Account #1**

ACCOUNT TYPE (e.g. Checking or Savings) \_\_\_\_\_

EMPLOYEE BANK NAME \_\_\_\_\_

BRANCH \_\_\_\_\_

CITY, STATE \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_

BANK ROUTING NUMBER (ABA#) \_\_\_\_\_

**Account #2**

ACCOUNT TYPE (e.g. Checking or Savings) \_\_\_\_\_

EMPLOYEE BANK NAME \_\_\_\_\_

BRANCH \_\_\_\_\_

CITY, STATE \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_

BANK ROUTING NUMBER (ABA#) \_\_\_\_\_

**This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**EMPLOYEE ID #**

\_\_\_\_\_  
**DATE**

**IMPORTANT:** Enter the employee's bank account and routing numbers into QuickBooks. To do this, click the Direct Deposit button on the Payroll and Compensation Info tab for each employee. This document must be signed by employees requesting automatic deposit of paychecks, and retained on file by the employer. Do not send this form to QuickBooks Direct Deposit.



**Aetna Voluntary Plans**  
 (formerly Aetna Affordable Health Choices®)  
**Enrollment/Change Request**

AccruePartners  
800457

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company).

**Instructions:** Read and fill out the Enrollment/Change Request (all pages). 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 ENROLLMENT/CHANGE REQUEST.**

**INFORMATION ABOUT YOU** Complete all information.

Print your name (first, middle initial, last) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of birth (MM/DD/YYYY) \_\_\_\_\_

Home address \_\_\_\_\_ Apartment number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ Email address \_\_\_\_\_ Sex  Male  Female Primary language spoken (Idioma principal) \_\_\_\_\_

**ACTION YOU WANT TO TAKE** Check the box next to the action you want to take.

**I am not currently enrolled and I want to...**

Enroll in the coverage choices selected below.  
 Decline this opportunity to participate.

**I am currently enrolled and I want to...**

Make changes to my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. (If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")  
 Update my personal and/or my dependent and/or beneficiary information.  
 Drop all of my current coverage choices.

Your payroll deductions will be taken after taxes are taken.

**YOUR COVERAGE CHOICES** Check (  ) the box for the level of coverage you want.

| Coverage type                                                                                    | Coverage level                                                                                                           | Weekly cost | Semimonthly cost |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------|------------------|
| Medical                                                                                          | <input type="checkbox"/> No Medical                                                                                      |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 28.13    | \$ 60.95         |
|                                                                                                  | <input type="checkbox"/> Yourself plus one .....                                                                         | \$ 70.96    | \$ 153.75        |
|                                                                                                  | <input type="checkbox"/> Yourself and family.....                                                                        | \$ 100.81   | \$ 218.42        |
|                                                                                                  | <i>Group limited benefit medical coverage is not available if you live and work in New Hampshire.</i>                    |             |                  |
| Hospital Indemnity                                                                               | <input type="checkbox"/> No Hospital Indemnity                                                                           |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 3.45     | \$ 7.48          |
|                                                                                                  | <input type="checkbox"/> Yourself plus one .....                                                                         | \$ 6.90     | \$ 14.95         |
|                                                                                                  | <input type="checkbox"/> Yourself and family.....                                                                        | \$ 10.35    | \$ 22.43         |
| <i>Coverage is not available if you live and work in New Hampshire.</i>                          |                                                                                                                          |             |                  |
| Vision                                                                                           | <input type="checkbox"/> No Vision                                                                                       |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 1.00     | \$ 2.17          |
|                                                                                                  | <input type="checkbox"/> Yourself plus one .....                                                                         | \$ 1.70     | \$ 3.68          |
|                                                                                                  | <input type="checkbox"/> Yourself and family.....                                                                        | \$ 2.40     | \$ 5.20          |
| <i>Coverage is not available if you live and work in New Hampshire.</i>                          |                                                                                                                          |             |                  |
| Dental                                                                                           | <input type="checkbox"/> No Dental                                                                                       |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 4.45     | \$ 9.64          |
|                                                                                                  | <input type="checkbox"/> Yourself plus one .....                                                                         | \$ 8.90     | \$ 19.28         |
|                                                                                                  | <input type="checkbox"/> Yourself and family.....                                                                        | \$ 14.69    | \$ 31.83         |
| Short Term Disability (STD)                                                                      | <input type="checkbox"/> No Short Term Disability                                                                        |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 3.50     | \$ 7.58          |
|                                                                                                  | <i>Coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.</i> |             |                  |
| Term Life Insurance                                                                              | <input type="checkbox"/> No Term Life                                                                                    |             |                  |
|                                                                                                  | <input type="checkbox"/> Yourself only.....                                                                              | \$ 1.54     | \$ 3.34          |
|                                                                                                  | <input type="checkbox"/> Yourself and family.....                                                                        | \$ 1.88     | \$ 4.07          |
| Please name your beneficiary. Beneficiary _____ Relationship: _____ Social Security Number _____ |                                                                                                                          |             |                  |

**YOUR AUTHORIZATION** You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request.

Your signature \_\_\_\_\_ Today's date (MM/DD/YYYY) \_\_\_\_\_

**EMPLOYER GROUP INFORMATION** This section is to be completed by your employer.

Employee ID \_\_\_\_\_ Hire date (MM/DD/YYYY) \_\_\_\_\_ Pay type \_\_\_\_\_ Total deduction (\$) \_\_\_\_\_ Effective date (MM/DD/YYYY) \_\_\_\_\_

Location or site code \_\_\_\_\_ Authorized signature \_\_\_\_\_ Title \_\_\_\_\_ Today's date (MM/DD/YYYY) \_\_\_\_\_

**INFORMATION ABOUT YOU** Repeat your name and Social Security number here.

Print your name (first, middle initial, last)

Social Security Number

**INFORMATION ABOUT YOUR DEPENDENTS** List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

|                                                                                                    |                                                                                                                                 |                        |                                                                                                                                                                                                         |          |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| <input type="checkbox"/> Add<br><input type="checkbox"/> Change<br><input type="checkbox"/> Remove | Print dependent's name (first, middle initial, last)                                                                            | Social Security Number |                                                                                                                                                                                                         |          |
|                                                                                                    | Sex<br><input type="checkbox"/> Male / <input type="checkbox"/> Female                                                          | Date of birth          | Enrolled in:<br><input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life |          |
|                                                                                                    | Relationship:<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____ |                        |                                                                                                                                                                                                         |          |
|                                                                                                    | Address (if different than yours)                                                                                               | City                   | State                                                                                                                                                                                                   | Zip code |
| <input type="checkbox"/> Add<br><input type="checkbox"/> Change<br><input type="checkbox"/> Remove | Print dependent's name (first, middle initial, last)                                                                            | Social Security Number |                                                                                                                                                                                                         |          |
|                                                                                                    | Sex<br><input type="checkbox"/> Male / <input type="checkbox"/> Female                                                          | Date of birth          | Enrolled in:<br><input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life |          |
|                                                                                                    | Relationship:<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____ |                        |                                                                                                                                                                                                         |          |
|                                                                                                    | Address (if different than yours)                                                                                               | City                   | State                                                                                                                                                                                                   | Zip code |
| <input type="checkbox"/> Add<br><input type="checkbox"/> Change<br><input type="checkbox"/> Remove | Print dependent's name (first, middle initial, last)                                                                            | Social Security Number |                                                                                                                                                                                                         |          |
|                                                                                                    | Sex<br><input type="checkbox"/> Male / <input type="checkbox"/> Female                                                          | Date of birth          | Enrolled in:<br><input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life |          |
|                                                                                                    | Relationship:<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____ |                        |                                                                                                                                                                                                         |          |
|                                                                                                    | Address (if different than yours)                                                                                               | City                   | State                                                                                                                                                                                                   | Zip code |

**MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT** Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. If your deductions are taken after taxes, you may drop or decrease coverage at any time. QLEs fall under one of these two categories:

**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 able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

**Family Status Change (FSC):** Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 30 days of the LOC/FSC.

**Loss of Other Coverage (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 coverage
- Dependent child losing eligibility as a dependent
- Other loss of coverage

**Family Status Change (FSC):**

- Divorce, legal separation or death
- Marriage
- Birth or adoption of a dependent
- Other

Date of LOC or FSC (mm/dd/yyyy)