

4. BASIC LIFE INSURANCE

For life insurance it is necessary to designate a primary beneficiary (P). It is also recommended that a secondary beneficiary (S) be selected in the case that the primary beneficiary may not survive you. A beneficiary may be a person, such as a spouse, parent or child, it could also be your estate or an institution. A secondary beneficiary would only receive benefits if all primary beneficiaries are deceased. Do not include yourself as a beneficiary.

P or S	NAME	RELATIONSHIP	S.S.#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 5 - PRIMARY CARE PROVIDER CHOICE (For Blue Care Network Enrollments ONLY)

Employee _____	Spouse _____
Child: _____	Child: _____
Child: _____	Child: _____
Child: _____	Child: _____

I CERTIFY THAT ALL INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT FALSE OR DECEPTIVE STATEMENTS WILL BE CONSIDERED FALSIFICATION OF COMPANY RECORDS AND MAY BE GROUNDS FOR TERMINATION.

_____ / ____ / ____
 (Employee's Signature) (Date)

WAVIER OF BENEFITS ONLY

Because the Plan is contributory and if I have refused the insurance, I understand that if I request coverage for myself and or my eligible dependents at a later date, I may be subject to special enrollment period restrictions.

I decline the following employee coverage's available to me:

- Medical ScriptGuideRx Life/AD&D

Employer's Name: _____

I am insured under another policy, please indicate below:

Carrier's Name: _____

I decline the following coverage's available to my spouse spouse & children children only

- Medical ScriptGuideRx

My dependents are insured under another policy or group plan, please indicate below:

Employer's Name: _____

Carrier's Name: _____

_____ / ____ / ____
 (Employee's Signature) (Date)

TO BE COMPLETED BY PERSONNEL

Group/Dept No. _____ Hire Date _____ Coverage Effective Date _____

Job Title _____ Hours Worked Per Week _____

- | | | | | |
|---|--|---|------------------------------------|---------------------------------|
| <input type="checkbox"/> Officer | <input type="checkbox"/> 5% Share Owner | <input type="checkbox"/> (HCE) Highly Compensated Employee | <input type="checkbox"/> Life/Ad&d | <input type="checkbox"/> Waiver |
| <input type="checkbox"/> BCN | <input type="checkbox"/> Blue Traditional | <input type="checkbox"/> CBPPO <input type="checkbox"/> ScriptGuideRx | | |
| <input type="checkbox"/> Address Change | <input type="checkbox"/> Dependent - Add or Delete | <input type="checkbox"/> Beneficiary Change | | |

New Group Code # _____ Coverage Termination Date _____

Other/Comments _____

Authorized Signature _____ Date _____