BENEFITS ENROLLMENT FORM

(PLEASE PRINT)

Name of Employee Last First Middle	**Social Security #**	**Date of Birth**	**Gender** ☐ Male ☐ Female
Address Street City State Zip Code		**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Date of Hire	☐ Full-Time ☐ Part-Time	**Occupation**	**Coverage Effective Date**
Work Status ☐ New Hire ☐ Rehire	**Hours Worked Per Week**	**Income $**	☐ Hourly ☐ Annual ☐ Monthly

Reason for Enrollment ☐ New Hire / First Time Eligible ☐ Open Enrollment
☐ Change in Coverage Request
☐ Qualifying Event Change **Type of Event**_____ **Effective Date**_____

I received and reviewed a copy of M.E. Simpson's Employee Benefits Summary. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

Medical Coverage with Anthem ☐ **Base Plan PPO $2,500** ☐ **Buy Up Plan PPO $1,000**
☐ Employee Only
☐ Employee & Spouse / Domestic Partner*
☐ Employee & Child(ren)
☐ Family
☐ Decline

Vision Coverage with Anthem
☐ Employee Only
☐ Employee & Spouse / Domestic Partner*
☐ Employee & Child(ren)
☐ Family
☐ Decline

Dental Coverage with Anthem
☐ Employee Only
☐ Employee & Spouse / Domestic Partner*
☐ Employee & Child(ren)
☐ Family
☐ Decline

Basic Life Coverage – Included at no Cost to the Employee **(Please complete the Beneficiary Designation on Page 2)**
☒ $15,000 of Life and AD&D Coverage with Anthem

Voluntary Life and AD&D with Lincoln Financial
☐ Elect – Please see separate information packet and enrollment form
☐ Decline

Short Term Disability and Long Term Disability with UNUM – Included at no Cost to the Employee
☒ Benefit Amount equal to 60% of your Income to a Maximum of $1,500 per week and $8,000 per month

*Domestic Partner coverage requires a completed Affidavit of Domestic Partnership.

IF APPLYING FOR DEPENDENT COVERAGE (Spouse or Child), complete the following:

Number of dependents (including spouse / domestic partner) _____

Name of Spouse (Last, First, MI)	**Date of Birth**	**Social Security Number**	**Gender**
			☐ M ☐ F

Name(s) of Child(ren) (Last, First, MI)	**Date of Birth**	**Social Security Number**	**Gender**
			☐ M ☐ F
			☐ M ☐ F
			☐ M ☐ F
			☐ M ☐ F

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any benefit payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from you employer. The Employee understands that her or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL:				**100%**

If the Primary Beneficiary(ies) dies before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL:				**100%**

DECLERATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/ her knowledge and belief. Each person understands that this information may be used to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition, if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For Changes Requested After Initial Enrollment Period Expires

I understand that if life or short term disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that coverage has been approved by the insurance company.

I also understand that if dental coverage is not elected, a waiting period may be required before certain services are covered.

For Payroll Deduction Authorization by the Employee

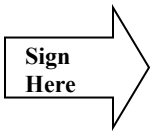
I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Please retain a copy of the fully completed form for your records and return the original to your employer

Signature The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.



Employee's Signature	Print Name	Date Signed