Effective January 1, 2013

2013 Open Enrollment
Employee Benefits

WHO TO CONTACT?

Need more information than this or the *Employee Benefit Guide for 2013* can provide? Please see one of your Human Resources professionals for answers to your questions.

Lanesia Forrest
Medical Benefits Specialist
205.325.2890
lforrest@libnat.com

Annual Benefit Enrollment is here!

Don't miss this opportunity to enroll in or make changes to your benefits.

Enrolling in Benefits

You may enroll in benefits as a new hire and during the annual enrollment period each year.

As you make your enrollment decisions for the coming year, keep the following points in mind:

- You cannot change your benefits during the year, unless you have a qualified family status change. For more information about qualified family status changes, see the Employee Benefit Guide for 2013.
- If you have been previously treated or diagnosed with a medical condition, you may be subject to a 12-month pre-existing condition exclusion. This exclusion may be reduced or waived depending on the length of previous creditable coverage.

Here are important dates to remember:

- **November 5, 2012 –** Annual Benefits enrollment begins for all employees.
- **November 16, 2012 –** Annual Benefits enrollment ends at 12 PM CST for all employees.
- **November 5 - December 31, 2012 –** Currently enrolled Blue Cross Blue Shield participants take the Health Assessment to reduce your premium. www.bcbstx.com/torchmark
- **January 1-31, 2013 –** Newly enrolled Blue Cross Blue Shield participants take the Health Assessment to reduce your premium. www.bcbstx.com/torchmark
- **January 1 –** Your 2013 benefit elections take effect January 1.

Do you need to enroll?

Yes:

Due to changes in plans offered, employees who wish to enroll or continue coverage must complete the enrollment process for the following benefits:

- Medical
- Health Savings Account
- Vision
- Dental
- Flexible Spending Account

Before you enroll…

- Read the information in this packet to learn what's new for 2013.
- For more details about all of your benefit choices, see the *Employee Benefit Guide for 2013*.

Ready to enroll?

Complete the 2013 Open Enrollment Election form and return to your local Human Resources department. If you are newly enrolling, making changes or cancelling coverage, you must complete the appropriate forms. The list of forms is located on page 3 of this guide.

New for 2013

2013 Benefit Guide available at www.tmkemployeebenefits.com

BlueCross BlueShield Medical Plan

For 2013, Medical coverage is offered through BCBS and is available in three plan options. **To continue your medical coverage, it is necessary that you select and enroll in one of these three plans:**

- Standard 800 *($800 Individual/$2400 family deductible)*.
- Select *($1250 individual /$3750 family deductible)* and
- Select Plus *(requires enrollment in the HSA plan, $1250 individual/ $2500 family deductible)*

Once you have enrolled, you cannot change your enrollment until the following Open Enrollment Period or unless you have a qualified change in your family status.

The 2013 medical rates are located on page 3 of this guide. For the detailed Medical Plan updates/changes and the IN-Network Plan Comparison, please review the 2013 Benefit Guide.

Health Savings Account *(HSA)*

A pre-tax Health Savings Account or HSA is offered to those who enroll in the BCBS Select Plus Medical Plan.

- It allows you to pay for many of the health care expenses not covered by your Medical, Dental, and Vision Plan including deductibles and copayments.
- This account is managed by Wells Fargo.
- You may contribute up to $3,250 for individual coverage or $6,450 for family coverage per calendar year.
- You may change the amount of your contribution at any time throughout the year and you can choose the amount of contribution cycles you would like to have the deduction taken out of.
- At age 55, you may contribute an additional $1,000.
- There is a monthly administration fee of $3.75.

There is no "use it or lose it" rule for the HSA account. At the end of the year, your balance carries over. Also, even if you change jobs, you control the funds in your HSA and decide when and how you want to use them. You also have 24/7 online access to your account and can manage your account online anywhere with Internet access. **Current participants must make a new election for 2013 to remain enrolled.**

DAVIS VISION Vision Plan

Davis Vision offers a separate vision plan that can be elected with or without medical coverage. The coverage includes a $10 exam copayment, $25 spectacle lenses copayment, and $25 contact lens evaluation, fitting, and follow-up care copayment. There are over 30,000 providers in their network.

The 2013 vision plan rates are located on page 3 of this guide.

MetLife® Dental Plan

MetLife® continues to offer Torchmark Corporation Affiliates with dental coverage. MetLife offers two plans: Full and Basic.

Flexible Spending Accounts *(FSA)*

An FSA account cannot be used for medical expenses if you are enrolled in the HSA account.

The 2013 maximum annual amount for medical reimbursement has changed due to health care reform. **The new annual maximum for medical reimbursement is $2,500.** The 2013 maximum annual amount for dependent reimbursement is $5,000 or $2,500 if married and filing separate tax returns. To enroll in the flexible spending accounts, continue your current contribution or change your contribution amount, remember to carefully estimate your anticipated expenses for 2013. For more information see the 2013 Employee Benefits Guide. **Current participants must make a new election for 2013 to remain enrolled.**

2013 Premiums

You pay for benefits through convenient payroll deductions. Medical, dental, vision, flexible spending account, and health savings account deductions are all pre-taxed.

If for any reason the weekly pay cannot cover medical, dental or vision premium payments, it is the responsibility of the employee to contact HR to make arrangements for payments in order to keep benefits from being cancelled for nonpayment.

Medical Insurance Rates

When it comes to health care, you and the Company share the cost of coverage. The following chart lists your weekly costs. These rates do not include the additional premiums for tobacco use, spousal coverage and the HRA.

Standard 800	Weekly Rate
Employee	$54.23
Spouse	$65.08
Per Dependent Child *(max 4)*	$24.69

Select	Weekly Rate
Employee	$33.69
Spouse	$49.85
Per Dependent Child *(max 4)*	$19.38

Select Plus	Weekly Rate
Employee	$33.69
Spouse	$41.77
Per Dependent Child *(max 4)*	$19.38

Rates based on 52 pay periods. Dependent children are eligible up to age 26.

Vision Insurance Rates

	Weekly Rate
Employee Only	$1.42
Employee + Spouse	$2.55
Employee + Child*(ren)*	$2.69
Employee + Family	$4.24

Rates based on 48 pay periods. Dependent children are eligible up to age 25.

Dental Insurance Rates

Plan A (Full) Coverage	Weekly Rate
Employee Only	$8.41
Employee Plus One	$17.14
Employee Plus Two or more	$28.60

Plan B (Basic) Coverage	Weekly Rate
Employee Only	$5.77
Employee Plus One	$10.86
Employee Plus Two or more	$18.20

Rates based on 48 pay periods. Dependent children are eligible up to age 25.

Open Enrollment Forms

- 2013 Open Enrollment Election Form
- BCBS Medical Enrollment Form
- Torchmark Corporation Medical Affidavit
- Wells Fargo Health Savings Account *(HSA)* Authorization Form
- MetLife® Dental Enrollment Form
- Davis Vision Enrollment Application
- Flexible Spending Account *(FSA)* Enrollment Form

Complete and Return These Forms:

To Enroll or Change coverage:

All	◦ 2013 Open Enrollment Election Form
Medical	◦ BCBS Medical Enrollment Form ◦ Torchmark Medical Affidavit
HSA	◦ Wells Fargo HSA Authorization Form
Dental	◦ MetLife® Dental Enrollment Form
VIsion	◦ Davis Vision Enrollment Application
FSA	◦ FSA Enrollment Form

Where are the forms?

All forms are in this packet or you can download them at *www.tmkemployeebenefits.com*.

2013 OPEN ENROLLMENT ELECTION FORM

RETURN THIS AND ALL APPLICABLE FORMS TO THE HUMAN RESOURCES OFFICE BEFORE NOVEMBER 16, 2012

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ◯ Cell ◯ Work		E-mail Address	
◯ HOURLY ◯ FIELD ◯ SALARY	Company ◯ AIL ◯ LNL			

Mark the appropriate change to the specific benefit below:

BlueCross BlueShield (BCBS) Medical Plan — Medical Insurance

◯ Decline All

◯ Add Dependent

◯ Delete Dependent

◯ Enroll In:

◯ Standard 800 *($800 individual / $2,400 family)*

◯ Select *($1,250 individual / $3,750 family)*

◯ Select Plus *(w/HSA $1,250 individual / $2,500 family)*

NOTE: If you are newly enrolling, making changes, or cancelling, you must complete the Medical Enrollment Form and the Torchmark Medical Affidavit

Wells Fargo HSA — High Deductible Health Savings Account *(available with BCBS Select Plus only)*

◯ Enroll ◯ Decline

NOTE: Only available with BlueCross BlueShield High Plan *($1,250 deductible)*. You must complete the Wells Fargo Enrollment Form

MetLife® Dental Plan

◯ Decline

◯ Add Dependent

◯ Delete Dependent

◯ Enroll:

◯ Plan A *(Full)*

◯ Plan B *(Basic)*

NOTE: If you are newly enrolling, making changes, or cancelling, you must complete the MetLife® Dental Enrollment • Change Form

DAVIS**VISION** — Vision Plan

◯ Enroll ◯ Decline

NOTE: If you are newly enrolling, you must complete the Davis Vision Enrollment Application

Flexible Spending Accounts (FSA)

◯ Enroll

◯ Decline

◯ Medical *($2,500 max)* ◯ Dependent Care ◯ Transportation

NOTE: To continue, change, or enroll, you must complete the FSA Enrollment Form

I authorize deductions to be made from my paychecks for the above selected benefits.

Print Name ____________ Signature ____________ Date ____________

MEDICAL PLAN ENROLLMENT FORM

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ○ Cell ○ Work		E-mail Address	

BlueCross BlueShield (BCBS) Medical Plan — Medical Insurance

○ Enroll ○ Add Dependent ○ Delete Dependent ○ Decline All

I elect the following Medical coverage: *(select one)*

○ **Standard 800** *($800 individual / $2,400 family)* ○ **Select** *($1,250 individual / $3,750 family)* ○ **Select Plus** *(w/HSA $1,250 individual / $2,500 family)*

○ Employee Only ○ Employee and _____ Child*(ren)* ○ Employee and Family, _____ Child*(ren)* ○ Employee and Spouse

Spouse Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Husband ○ Wife		

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter		

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter		

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter		

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter		

MEDICAL PLAN ENROLLMENT FORM

Previous Health Coverage Information — *MUST COMPLETE THIS SECTION IF NEWLY ENROLLING*

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. If more than one plan was in effect, or if information is different for dependents, attach additional pages.

List names of every individual covered:

Primary Enrollee Name, Last	**First**	**MI**	**Sex** ○ **Male** ○ **Female**	**Date of Birth** *(mm/dd/yyyy)*
Relationship to Applicant ○ **Self** ○ **Spouse** ○ **Dependent**	**Employer Name**		**ID Number**	**Group or Policy Number**
Name and Address of other insurance company, TPA, HMO	**Employment Information** Employment Date ______ Effective Date ______ Will Coverage be Continued? ○ Yes ○ No If No, Expected Cancellation Date ______		**Type of Policy** ○ Employer Sponsored ○ Individual Purchase	**Type of Coverage** ○ Self ○ Family ○ Employee / Spouse ○ Employee / Child

All BCBS employee participants must complete the *Torchmark Medical Affidavit.*

ACKNOWLEDGEMENT

This will certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected coverage or declined coverage as indicated. If I desire to apply for coverage at a later time, I understand that there may be a delay in the effective date of coverage as well as a pre-existing condition waiting period. I authorize necessary payroll deductions by my Employer to cover the cost of my coverage(s) and that these deductions will remain in effect for the duration of the plan year. I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

____________________ ____________________ __________
Print Name Signature Date

TORCHMARK CORPORATION MEDICAL AFFIDAVIT

READ THIS AFFIDAVIT CAREFULLY — IF THIS FORM IS NOT RETURNED, ADDITIONAL PREMIUMS MAY APPLY

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #

Address, Street	City	State	ZIP

Phone, Home	Alternate ◯ Cell ◯ Work	E-mail Address

SPOUSE AFFIDAVIT

THIS SECTION MUST BE COMPLETED BY ALL EMPLOYEES REQUESTING COVERAGE FOR THEIR LAWFUL SPOUSE ON THE TORCHMARK MEDICAL PLAN.

Torchmark Corporation has implemented a "Spousal Additional Premium Charge". Under this policy, if your spouse is eligible for medical coverage with his or her own employer, you will be charged an additional monthly premium to cover your spouse on the TMK Plan.

Name, Last	First	MI	Date of Birth *(mm/dd/yyyy)*

1. Is your Spouse Employed?

- ◯ **Yes**
- ◯ **No** *(skip to next section)*

2. Is your Spouse eligible for Medical Benefits through his/her employer?

- ◯ **Yes,** My Spouse is eligible for Medical Coverage through his/her employer
- ◯ **No,** My Spouse is Not eligible for Medical Coverage

SPOUSE'S EMPLOYER CONTACT INFORMATION:	Contact Name	Contact Phone

TOBACCO/ NICOTINE USE AFFIDAVIT

THIS SECTION MUST BE COMPLETED BY ALL EMPLOYEES REQUESTING COVERAGE ON THE TORCHMARK MEDICAL PLAN.

Tobacco Additional Premiums apply only if you smoke or have used tobacco products in the last 90 days prior to Enrollment. Failure to complete this affidavit will require you to pay this additional premium **even if you are a non-tobacco user**. If you complete this form and declare that you are a non-tobacco user and later identified as a tobacco user, then you will be required to pay the Tobacco Additional Premium. The premium will be waived after you have completed a smoking cessation program and are smoke-free for 90 days.

Select the statement that best describes you:

No Tobacco Additional Premium

◯ I affirm that I *have not used* tobacco over the last 90 days.

Tobacco Additional Premium

◯ I affirm that I *have used* tobacco over the last 90 days.

ACKNOWLEDGEMENT / FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

I agree and acknowledge:

(i) that I have read this form and understand the Spousal Additional Premium Charge and Tobacco Additional Premium Charge;
(ii) that the information provided on this form is complete and true to the best of my knowledge;
(iii) that it is my responsibility to notify Torchmark Corporation Human Resources Department of changes to the responses provided on this form within 30 days of such change, such as a change in my spouse's employment status or a change in my spouse's eligibility for medical coverage through his or her employer; and
(iv) any material misrepresentation made by me on this form, including my tobacco/nicotine use history, may void the insurance, pursuant to the Incontestable Clause of the policy.
(v) that intentionally reporting incomplete or incorrect information to obtain or maintain medical coverage is fraud punishable by termination of employment, termination of coverage under Torchmark's Medical Plan retroactive to the date of the fraud, including spousal and dependent coverage.

Print Employee Name ______________________ Employee Signature ______________________ Date ______________

2013 HEALTH SAVINGS ACCOUNT ENROLLMENT FORM

WELLS FARGO HEALTH SAVINGS ACCOUNT (HSA)

EMPLOYEE IDENTIFYING INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ○ Cell ○ Work		E-mail Address	
Country of Citizenship			Date of Birth *(mm/dd/yyyy)*	
Residency Status	○ U.S. Citizen	○ Permanent/Resident Alien	○ Non-Permanent/Non-Resident Alien	

HEALTH SAVINGS ACCOUNT (HSA) ELECTION — *BCBS Select Plus Health Plan ONLY*

Employee Annual Election $	To be contributed in (select one)	○ **Single Annual** installment ○ **Each Pay Period** installments ○ ______ installments (maximum 52)

Please note that the sum of the Employee Annual Election cannot exceed the IRS' mandate of $3,250 for an individual / $6,450 for a family.

○ **$ __________ Catch-up contribution for Ages 55 and above** *(Deducted per pay period; Maximum contribution $1,000)*

____
(Please initial)

I understand that I will be subject to $3.75 monthly maintenance fee that will be charged to my HSA account.

Please fill out, sign and return this form to your Employer.
Do not send this form to Wells Fargo Health Benefit Services

Enrollment Election

I want to establish a Health Savings Account *("HSA")* at Wells Fargo Bank, N.A. *("Wells Fargo")*. I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I understand that I may access the agreements governing my HSA via the Wells Fargo Health Account Manger[SM] web portal online at *https://healthbenefits.wellsfargo.com/hbs* or by calling 866-884-7374. I further understand that a copy of the agreements governing my HSA will be sent to me in a "welcome packet" after my HSA is opened and that I will have seven *(7)* business days to revoke my HSA after the welcome packet is sent.

Appointment of Employer as Special Agent for Account Opening Purposes

By signing in below, I appoint ___Torchmark Affiliates___ *("Employer")* as my special agent for purposes of opening a Wells Fargo HSA.

As my special agent, Employer will receive a notice from Wells Fargo on my behalf, which explains that, consistent with its efforts to help the government of the United States fight money laundering activities and terrorism funding, Wells Fargo obtains, verifies, and records information to identify each individual who opens a Wells Fargo HSA. I hereby provide the Identifying Information listed above to Employer and authorize Employer to forward this information to Wells Fargo on my behalf in furtherance of my establishing a Wells Fargo HSA.

I agree that Employer will be my special agent unless and until the earlier of the following three events occurs: *(i)* I submit written notice to Employer that I intend to terminate this appointment, and Employer has a reasonable period of time to act on such notice; *(ii)* I receive my HSA "welcome packet" from Wells Fargo; or *(iii)* I receive a notice from Wells Fargo that my application for an HSA has been declined.

Signature of Employee

By signing below, I agree to the above. I also authorize Wells Fargo to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA. This may include ordering my credit *(or other)* report *(e.g. information from any motor vehicle department or other state agency)*.

Print Name	Signature	Date

MetLife

Metropolitan Life Insurance Company, New York, NY

DENTAL ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Torchmark Corporation	**104282**	**104282**		

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Dental Insurance

Select your level of coverage

- ☐ Employee Only
- ☐ Employee + One Dependent (Spouse or Child)
- ☐ Employee + Two or More Dependents (Spouse and Children)

Select your plan type

- ☐ Plan A (Full)
- ☐ Plan B (Basic)

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

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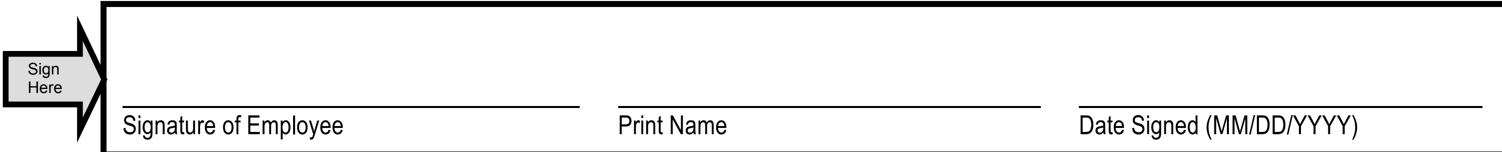
DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.



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DAVIS VISION ENROLLMENT APPLICATION

SUBSCRIBER INFORMATION *(PLEASE PRINT)*

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ○ Cell ○ Work		E-mail Address	

Reason for Application ○ Addition ○ Change ○ Reinstate ○ COBRA ○ Termination ○ Waive Coverage

Type of Coverage ○ Subscriber Only ○ Subscriber and Spouse ○ Family ○ Subscriber and Child ○ Subscriber and Children

DAVISVISION — TYPE OF COVERAGE

Subscriber Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Self	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	
Spouse Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Spouse	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	
Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	
Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	
Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	
Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Disabled	

ACKNOWLEDGEMENT

"I certify that this enrollment information is true and correct."

Print Name ____________ Signature ____________ Date ____________

2013 FLEXIBLE SPENDING ACCOUNTS ENROLLMENT FORM

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	**City**		**State**	**ZIP**
Phone, Home	**Alternate** ○ Cell ○ Work		**E-mail Address**	

Write in the annual amount you wish to contribute to your Flexible Spending Account for 2013.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care Spending Account *($2,500 Maximum)*	**$**
Dependent Care Spending Account *($5,000 Maximum or $2,500 maximum if married and filing a separate tax return)*	**$**
If you are married and plan to open a Dependent Care Spending Account, please indicate whether you are planning to file a joint or separate income tax return this year.	○ **File Joint** ○ **File Separate**
Transportation Spending Account *(You can contribute the monthly rate charged for parking up to $240, and up to $125 per month for mass transit)*	**$**

An FSA account cannot be used for medical expenses if you are enrolled in the HSA account, but can be used for vision and dental expenses.

ACKNOWLEDGEMENT

I authorize the reduction of my gross earnings by the amount designated above. I wish to have this amount deducted in equal amounts over 52 pay periods.

I understand that amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred during the period of coverage, will be forfeited in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status (i.e., marriage, divorce, death of spouse, birth or adoption, termination of employment, unpaid leave of absence of employee or spouse, or any significant change in spouse's employment, hours or health coverage because of spouse's employment.)

Print Name ____________________ Signature ____________________ Date ____________