HEALTH & WELFARE BENEFITS CHANGE FORM

PLEASE SELECT ONE (New hires must enroll *prior* to their 6 month anniversary by calling People Strategy Benefits at

☐ Rehire* and **

☐ Change to Full-Time*
Date____________________

☐ Add Dependent(s)*

☐ Drop Dependent(s)*

☐ Add Coverage*

☐ Drop Coverage*

☐ Other ____

Specify coverage added: ______________________

Specify coverage dropped: ______________________

***If you are adding/enrolling for medical coverage, the following items are required: 1) *TOBACCO USE TEST* REQUIRED FOR EMPLOYEES AND SPOUSES 31 DAYS FROM THE DATE YOU SIGN THIS FORM; 2) The attached *NON-SMOKER/SMOKER CERTIFICATION; AND 2)* The attached *DEPENDENT ELIGIBILITY VERIFICATION AND TRANSMITTAL FORM* for dependent Medical coverage; and 3) For all plans, r*equired SUPPORTING DOCUMENTATION* (see page 2 for details)**

****Important Information about Reinstatement of Coverage –** If an Employee Partner loses medical, dental or vision coverage due to termination of employment or reduction of hours and elects and maintains COBRA under the ClubCorp Health Benefits Plan until rehired by an Employer participating in the ClubCorp Health Benefits Plan, the Employee Partner will be treated as newly eligible. If an Employee Partner does not elect and maintain COBRA under the ClubCorp Health Benefits Plan until rehired by a participating Employer, the Employee Partner must again complete 6 months of consecutive service, and enroll prior to the end of the 6 month anniversary.

1. ABOUT YOU

Name: ____ **Social Security #:**______________________

Phone Number (s): ________________________________ **Email Address:** __________________________

Male_____ Female _____ Single _____ Married _____ Birth Date: Month___________Day_________Year________

<u>I elect to enroll myself in</u>:

☐ **Medical Plan 750 *or*☐HDHP Medical Plan** **(Attach *NON-SMOKER/SMOKER CERTIFICATION FORM* FOR MEDICAL PLAN)**
☐ **Dental DPO *or* ☐ Dental DHMO DHMO Provider Number __________________ (Select at enrollment or one will be assigned)**
☐ **Group Life Insurance/Accidental Death & Dismemberment *(please complete Designation of Beneficiary Form)***
☐ **Long Term Disability (LTD) – eligible positions only *(refer to Benefits Guide for listing of eligible positions)***
☐**Short Term Disability (STD) – available to Employee Partners *NOT* eligible for LTD. Please also complete STD enrollment form for qualifying life events, including a change from *part-time to full- time (see back)***
☐**Supplemental Term Life (<u>must</u> complete Supplemental Life Insurance Application)**
☐**Vision**

<u>I elect **not** to enroll myself in</u>:
☐**Medical** ☐**Dental** ☐**Life/AD&D** ☐**LTD** ☐**Vision** ☐**STD**

By rejecting coverage under the Medical/Dental/Life/Vision/LTD and STD Plans, I understand that my only opportunities to enroll in the future are: 1) I have a qualifying life event (see back of form) or 2) during the Annual Open Enrollment Period. If you enroll in the STD Plan during open enrollment, your enrollment may be subject to evidence of good health.

2. DEPENDENTS *(DEPENDENT VERIFICATION IS REQUIRED FOR MEDICAL– SEE REVERSE)*

☐ **I do <u>not</u> choose** to enroll my dependent(s) and I understand that they will not have the opportunity to enroll in the future unless due to a qualifying life event or during the Annual Open Enrollment Period.
☐**I choose to enroll my dependent(s) in** Medical, Dental and/or Vision *(indicate coverage in the space below)*
List any eligible dependent(s)* by name and the coverage you are electing for that dependent. Only the dependent(s) listed will receive coverage. If the number of dependents exceeds the number of spaces available, please attach a list identifying those not included below, as well as the information requested.

Eligible Dependent*	Relationship	SS#	Birth Date	Plan (i.e., Medical, Dental, Vision)
	Spouse			

*Eligible dependent is defined on the back of this form. **It is the <u>Employee Partner's responsibility</u>** to notify the Plan Administrator when a dependent loses eligibility status.

3. DEDUCTIONS

I authorize ClubCorp, Inc. ("ClubCorp") and my employer, if an affiliate of ClubCorp, to deduct from each paycheck any contributions or other amounts authorized by me, in writing or orally, in relation to any of the ClubCorp sponsored employee benefit plans ("Plans"). I will follow any guidelines for making contributions, withholding, coverage elections and other designations under the above Plans as communicated to me. I understand that Payroll deductions for benefit elections are not pro-rated based on coverage effective or end dates. Payroll deductions for any change in benefit elections due to a status change or special enrollment event are processed when received and I understand that I will not be charged for any increases in coverage that are effective before the date my change is submitted as the result of the change. I also understand that I will not receive any refund for changes when dropping coverage for any period prior to my submission of the change request even though coverage will be changed as of the effective or end dates related to the event triggering the change. I understand that I am responsible for timely submitting my change and that the date I submit the change election determines when the change to my payroll deductions will occur and that there will not be any retroactive adjustments to my payroll deductions. I understand that I must submit my change election due to a qualifying event within 31 days of the event triggering the change, except events of becoming covered or losing coverage under Medicaid or CHIP, and these changes must be submitted within 60 days of the change in such coverage. I further agree to be bound by any oral elections, instruction, or notice made under these Plans.

Employee Signature____ Date______________________

Eligible Dependents – PROOF OF DEPENDENT STATUS IS REQUIRED FOR MEDICAL BENEFITS! PLEASE COMPLETE THE ATTACHED *DEPENDENT ELIGIBILITY VERIFICATION AND TRANSMITTAL FORM!* This must be received no later than 31 days after effective date of Medical coverage for new hire enrollments or within 31 days of qualifying life event. (Changes due to becoming eligible for coverage under Medicaid or CHIP or losing coverage under the same must be requested within 60 days of the change in eligibility for Medicaid or CHIP.)

Your Eligible Dependents
Newly eligible dependents must be U.S. citizens or legal residents in the U.S at the time of coverage and are defined as:

1. Legal spouse means your husband or wife as defined under Federal Law and who is a U.S. citizen or legal resident.
2. Medical Plan Only – dependent children up to age 26 (includes stepchildren, legally adopted children or children placed with you for adoption, and foster children), whom are a United States citizen or legal resident.
3. For Non Medical Plans – Your unmarried dependent children up to age 25 whom are United States citizens or legal residents and who are primarily dependent on you for financial support.
4. Your dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

When You Can Enroll and When Coverage Becomes Effective

- ***As a new hire,*** you must enroll prior to your six-month anniversary. Coverage is effective on your six-month anniversary.
- For Medical, Dental and Vision coverage, ***you have 31 days from the qualifying life event to enroll or change your coverage election*** and the effective date is the day of the qualifying life event. (*Changes due to becoming eligible for coverage under Medicaid or CHIP or losing coverage under the same must be requested within 60 days of the change in eligibility for Medicaid or CHIP*)
- For Group Life and AD&D, Supplemental Life, LTD and STD coverage, ***you have 31 days from the qualifying life event to enroll or change your coverage election*** and the effective date is the day you enroll.
- Annual Enrollment is your time to make changes to your benefit elections without a qualifying life event. Coverage is effective on January 1 of the following year.

Qualifying Life Events
Medical/Dental/Vision and Life Plan pretax premium election remains in place for the entire Plan Year, unless you experience a qualifying life event. Qualifying life events include:

- Change in your legal marital status (marriage, divorce, or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
  NOTE: The Plan will not automatically pay newborn claims unless you complete and submit your enrollment form to add them as a dependent within 31 days from the date of birth.
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of coverage
- Entitlement to Medicare
- You or your dependent becoming or losing coverage under Medicaid or CHIP.

Supporting Documentation Required for Qualifying Life Events
You must notify the Plan Administrator within 31 days of the event. However for a change due to gaining or losing eligibility for Medicaid or CHIP requires you to notify the Plan Administrator within 60 days of the change. Supporting documentation is required. Some examples of supporting documentation include:

Loss of coverage	Document/letter stating why coverage ended and when, and who was enrolled
Addition of spouse due to marriage	Copy of the marriage certificate
Divorce (Drop dependent)	Copy of the divorce decree
Birth	Copy of hospital bill, birth certificate or social security card

Call People Strategy Benefits at 1-800-800-4615 with any questions about completing the benefits change form

Send Original to ClubCorp Benefits
3030 LBJ Freeway, Suite 600, Dallas, TX 75234
or by Fax to 972-888-7558

Employee Partner Should Keep a Copy

ATTENTION! MEDICAL PLAN ENROLLEES
For Qualifying Life Events and Reinstatement of Medical Coverage!
Please read this information carefully

Certification Form
You must complete and sign the form on the back and return it to ClubCorp Benefits with your Health Benefits Change Form

Non-Smoker/Smoker Process and Definitions
In an effort to encourage overall good health for covered Employee Partners and their covered dependents, Employee **Partners and dependents covered under the ClubCorp Medical Plan who are non-smoker/non-tobacco users can receive discounted medical contributions on their medical plan coverage effective date**.

Upon enrollment, you will be required to certify the tobacco user status for you and any covered dependents. Please read this information carefully before you call to complete this certification form on the tobacco user status for you and any dependents.

You and your covered spouse will be required to complete the tobacco use test at no cost to you at an approved location typically within 31 days from the date of your enrollment confirmation letter in order to receive the contribution rate discounts. This form certification of you and your covered spouse's tobacco user status will remain in effect for the next 31 days until both of you complete the tobacco use test. The results of the tobacco use test will be used to maintain your and your covered spouse's tobacco user status at the end of the 31 days and for the remainder of the plan year. If you and/or your covered spouse do not complete the tobacco use test within 31 days from the date of your enrollment confirmation letter, you will not be eligible to receive the Medical Plan discounted rate until you complete the tobacco cessation program. **More information about the free tobacco use test can be requested by calling People Strategy Benefits at 1-800-800-4615.**

For those covered Employee Partners and dependents who are smokers/tobacco users, ClubCorp is offering assistance with the company-sponsored smoking/tobacco cessation program through the American Institute for Preventive Medicine. **You and/or your covered dependents can participate in the Medical Plan smoking/tobacco cessation program (at no cost to you) beginning on your coverage effective date.** Upon receipt of proof of participation in the smoking/tobacco cessation program, you will receive the discounted medical plan contributions.

If it is unreasonably difficult due to a health factor for you to meet the requirement or if it is medically inadvisable for you to attempt to meet the requirements of this program, we are making available a reasonable alternative standard for you to obtain the discounted medical plan contributions – the Medical Plan smoking/tobacco cessation program. If satisfying this reasonable alternative outlined above is medically inadvisable and you can provide a physician's statement indicating so, then please contact the ClubCorp Benefits Department, who will work with you to develop an additional reasonable alternative.

Proof of Participation in the Medical Plan smoking/tobacco cessation program is a certificate/diploma issued to the participant by the American Institute for Preventive Medicine after a participant has completed the program requirements and final exam (with a passing score).

To enroll in the Medical Plan smoking/tobacco cessation program, please call the American Institute for Preventive Medicine at 1-800-345-2476 x233. You or your covered dependents can enroll any time once your Medical Plan coverage becomes effective.

One is considered a **non-smoker/non-tobacco user** if you (or your covered dependents)**:**

- have not used tobacco products (cigarettes, cigars, chewing tobacco, etc.), for at least 6 months prior to signing this certification, and you test negative for tobacco, or
- enroll in the ClubCorp Medical Plan smoking/tobacco cessation program offered in partnership with the American Institute of Preventive Medicine and provide proof of participation. Upon receipt of the proof of participation from you, ClubCorp Benefits will apply the discounted medical plan contributions.

One is considered a **smoker/tobacco user** if you:

- certify by completing this certification form that you have used tobacco based products (cigarettes, cigars, chewing tobacco, etc.) within the last 6 months (from the date you sign this form), or
- are currently using any form of tobacco (cigarettes, cigars, chewing tobacco, etc.) in any amount (including occasional social use), and test positive for tobacco, or
- do not take the tobacco test or test positive for tobacco, or
- if any of the above applies and you do not enroll in the ClubCorp Medical Plan smoking/tobacco cessation program.

See reverse side for more information

Definition of smoker: an employee who smokes cigarettes, cigars or chews tobacco, etc. Casual or social smoking constitutes smoking by the ClubCorp Medical Plan definition.

Right to request documentation: ClubCorp Benefits has the right to request documentation at any time from an employee or dependent who declares him/herself a smoker enrolled in the approved smoking/tobacco cessation program or from the vendor providing the smoking/tobacco cessation program to the employee or dependent for the sole purpose of verifying enrollment and participation.

An employee or dependent that is unable to provide proof of participation in the ClubCorp Medical Plan smoking/tobacco cessation program will be subject to revocation of the non-smoker contribution discount.

Recourse for making a false statement: *An Employee Partner who intentionally falsifies his/her or covered dependent's non-smoking status will be subject to immediate revocation of the non-smoker contribution discount and could face a loss of coverage for intentional falsification of enrollment.*

Non-Smoker/Smoker Certification Form

Certification (to be completed by the employee for himself/herself and on behalf of all covered dependents):

After reading the information provided, please (place an "X" before the appropriate statement). I hereby certify that I and my covered dependents are:

☐ Non-smokers/non-tobacco users eligible for the non-smoker contribution discount for the Medical Plan effective on my qualifying life event/reinstatement of benefits effective date.

☐ A smoker (either the employee or at least one dependent) and I acknowledge that I am not eligible for the non-smoker contribution discount on my qualifying life event/reinstatement of Benefits effective date. I also understand that either I can and/or any one of my covered dependents can participate in the Medical Plan approved smoking/tobacco cessation program in order to qualify for the non-smoker contribution discount for the Medical Plan premium. I understand that it is my responsibility to enroll in the smoking/tobacco cessation program with the American Institute for Preventive Medicine and I will be asked by ClubCorp Benefits to provide proof of participation. In addition, I understand that ClubCorp Benefits may verify enrollment and activity with the program vendor. Once I provide proof of participation in the smoking/tobacco cessation program to ClubCorp Benefits, I will receive the discounted medical plan contributions effective upon receipt by ClubCorp Benefits.

If you do not complete this certification, you and your covered dependents will be ineligible for the non-smoker Medical Plan contribution discount, regardless of your smoking/tobacco use status. You will be defaulted to the smoker contribution beginning on your medical plan coverage effective date. You may be required to update your smoking status and/or be tested at each subsequent annual open enrollment period for the medical plan in order to qualify for the Medical Plan non-smoker contribution discount.

________________________ __________________ ______________
Employee Partner Signature Social Security # or Employee #

________________________ __________________ ________________________
Employee Partner Printed Name Date Club/Resort Name or Club/Resort #

Please list the names of any dependents <u>who are smokers/tobacco users</u>:

____ ________________________
Dependent Name Relationship

____ ________________________
Dependent Name Relationship

____ ________________________
Dependent Name Relationship

More information about the free tobacco use test can be requested by calling People Strategy Benefits at 1-800-800-4615.

IMPORTANT ACTION REQUIRED
DEPENDENT ELIGIBILITY VERIFICATION
AND TRANSMITTAL FORM

The ClubCorp **Medical Plan** requires all employees to provide proof of eligibility for all dependents. Instructions on how to submit verification and documentation requirements are attached.

Medical coverage for your dependents will not become effective until they have successfully been verified. **The required documentation must be received by ClubCorp Benefits no later than 31 days after the effective date of coverage.** If you are a new hire, the effective date of coverage is your six month anniversary. If you have a status change or special enrollment event, the effective date is the event date (i.e., date of birth, date of marriage, date coverage was lost).

If the required documentation is not received or verified for your dependents as indicated, you will not have another opportunity to enroll your dependents for **Medical coverage** until the next annual open enrollment.

We understand this process requires both time and effort on your part. We appreciate your commitment in helping ClubCorp, Inc. maintain compliance and manage healthcare costs by ensuring that only eligible dependents are enrolled.

ClubCorp's dependent eligibility medical plan requirements are as follows:

Covered Dependents	**Description**
Spouse	Legally married husband or wife as defined by Federal Law who is a U.S. citizen or legal resident of the U.S.
Common Law Spouse	Only applicable in the following states: Alabama, Colorado, Georgia (if before 1/1/97), Idaho (if before 1/1/96), Iowa, Kansas, Montana, Ohio (if before 10/10/91), Oklahoma, Pennsylvania (if before 1/1/05), Rhode Island, South Carolina, Texas, Utah, and Wash., D.C.
Children to age 26	• Biological • Step • Adopted • Legal Guardianship
Children – Disabled over age 26	• Must be medically certified as disabled

HOW TO VERIFY YOUR DEPENDENTS ARE ELIGIBLE
In order to verify that your **newly enrolled or added** dependents are eligible for medical coverage, you will need to provide COPIES of the required document types within 31 days after the effective date of coverage or within 31 days of a status change or special enrollment event.

Step 1: Review the attached list of ***Acceptable Documentation***

Step 2: Gather all the necessary documents
Step 3: Forward the documents with the attached ***Dependent Eligibility Form***. It is important to fill out the form completely and return it with your documents. Incomplete or non-receipt of forms could cause delays in processing your dependents and coverage may not begin.

See reverse side for more information

Acceptable Documentation
(Please submit COPIES only)

Spouse		Government-issued Marriage certificate and 2010 or 2011 Federal Tax Return*
Common Law Spouse		Affidavit of Common Law Marriage and Proof of Joint Ownership issued with the last 6 months
Children – Biological		Government-issued Birth certificate
Children – Step		Government-issued Birth certificate and Government-issued Marriage certificate
Children – Adopted		Adoption Certificate (or pre-adoption order or placement order issued by a court)**
Children – Legal Guardianship		Government-issued Birth certificate and Court order of legal guardianship
Children – Disabled		Government-issued Birth certificate and Medical certificate of disability from a healthcare provider

***Only page 1 and the signature pages are required. Please black out financial information.**
** Must be within 30 days of placement for adoption or adoption being finalized if child not adopted at enrollment

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Dependent Eligibility Verification Transmittal Form
Due Date: 31 days from effective date of coverage or within 31 days from status change/special enrollment event

Employee Name: ________________________________ Phone Number:_____________________________

Employee SS#: ________________________________ Email Address: ______________________________

Instructions:

1. Please fill in your dependent's name and the type of dependent they qualify for next to each name.
2. Review the table above titled "Acceptable Documentation". Based upon the type of dependent, list the documents you will use to support the dependent's eligibility next to their name.
3. **This form must be submitted along with the COPIES of all documents listed below**. You may fax this completed form and documents to 972-888-7558, e-mail to pssupportcenter@clubcorp.com or mail it to the address listed below:

ClubCorp Benefits
3030 LBJ Freeway, Suite 600
Dallas, TX 75234

If you have any questions, please feel free to call ClubCorp Benefits 1-800-800-4615

Dependent Name	**Dependent Type (Child, Spouse, etc.)**	**Dependent SS#**	**Documents Included As Verification**

I hereby certify the information on this form and documentation I am providing about my dependents is true and correct to the best of my knowledge:

__________________________________ ______________________

Signature Date