ABS - AMERICAN BUILDING SUPPLY, Inc.

2011-2012 BENEFIT ENROLLMENT/CHANGE FORM Please complete this form in its entirety.

1. EMPLOYEE INFORMATION (Please Print CLEARLY)

Last Name	First Name	Middle Initial	☐ Male ☐ Female	☐ Single ☐ Married ☐ Registered Domestic Partner	*(HR USE ONLY)* Event Date

Home Address			Social Security Number		**Coverage Effective Date:** 9/1/2011
City	State	Zip Code	Date of Birth	Date of Hire	❑ New Hire ❑ Rehire ❑ Part Time to Full Time ❑ Newborn/Adoption ❑ Marriage/Divorce ❑ Loss of Coverage ☒ **Open Enrollment** ❑ Change of Address ❑ Other:
Home Phone	Work Phone		Location/Branch		
Mailing Address (if different from above)					

Qualifying Events- Making Changes To Your Enrollment – PLEASE READ
If you experience a qualifying life event that allows you to make changes to your enrollment in the health plan coverage, you must report your change within 31 days of the event. If you do not report your change within that time the company and insurance carrier can deny your request for the change. Please provide proof or documentation of the event with your enrollment or change. If proof is not available at the time you turn in your form, you must produce it upon request or within the timeline provided by the company or insurance carrier.

2. PLAN ELECTIONS ☑ Check the appropriate box(es) below to elect or change coverage.

EMPLOYEE BENEFIT CONTRIBUTIONS ARE TAKEN PRE-TAX. ❑ ***CHECK HERE TO CHANGE CONTRIBUTIONS TO AFTER-TAX.***

MEDICAL PLAN CHOICES	ELECTION	GROUP ID	Enrollment Unit/Sub-Group	ANCILLARY PLAN CHOICES	ELECTION	GROUP ID	Enrollment Unit/Sub-Group
Medical Plan Selection- PLEASE PICK ONE OF THE FOLLOWING				**Please check the box below for EACH plan you are electing.**			
				DENTAL: United Healthcare	☐	**717294**	
United Healthcare PPO Buy-Up	☐	**717294**		**VISION :** Superior Vision	☐	**29778**	
VOLUNTARY LIFE: (Separate Form Required)	☐	**302372**		**LIFE :** Employer Paid Life	☒	**302372**	

3. EMPLOYEE & DEPENDENT PERSONAL INFORMATION Complete for yourself and your dependent(s) whether you elect coverage or not.

Type of Change: P = Plan Change C= Carrier Change E = Enroll D = Delete NC = No Change

Type of Change	Name	M/F	Date of Birth	Social Security Number	IRS Dependent	Disabled?	HMO only Primary Care Physician Name	HMO Physician Enrollment ID	Current Patient Y/N?
	Self -					Y / N			
	Spouse (or AB 2208 Domestic Partner)					Y / N			
	Child 1 -				Y / N	Y / N			
	Child 2 -				Y / N	Y / N			
	Child 3 -				Y / N	Y / N			
	Child 4 -				Y / N	Y / N			

4. OVERAGE DEPENDENT CHANGE

I understand that my dependents over age 19 up to age 25 turning 26 can remain on my plan regardless of their student status effective 9/1/11.

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5. EMPLOYEE & DEPENDENT COVERAGE ELECTION

Eligible Enrollees	Enroll in MEDICAL Plan?	Enroll in DENTAL Plan?	Enroll in VISION Plan?	Other Medical Coverage?
Employee	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Spouse/Registered Domestic Partner	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Child 1	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Child 2	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Child 3	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Child 4	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No
Child 5	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No	❑ Yes / ❑ No

6. WAIVING MEDICAL COVERAGE – MUST BE COMPLETED IF WAIVING/DECLINING/CANCELING MEDICAL COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. This 31-day period is called the special enrollment period. A special enrollee will be, if applicable, subject to a maximum pre-existing condition limitation or exclusion for 6 months (the same as for a regular enrollee). A special enrollee is not a late enrollee. Proof of creditable coverage from other insurance will apply towards the pre-existing limitation. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a Qualified Status Change. If you are declining enrollment for any other reason, or if you fail to complete this form, you may be subject to certain policy or plan provisions including but not limited to enrollment permitted only during the annual enrollment period and a 6 month pre-existing condition limitation or exclusion period upon enrollment.

I am declining coverage for: ☐ Myself ☐ My Spouse ☐ My Child(ren) ☐ Myself, My Spouse, and My Child(ren)

I am presently declining medical coverage for the individuals checked above. Check one:

- ☐ I (we) have other medical coverage.
- ☐ I (we) have Medicare/Medical.
- ☐ I (we) do not have other medical coverage.

I have read the above and acknowledge that I have been given the opportunity to enroll myself and (if applicable) my eligible dependents. I also acknowledge receipt of this Notice.

Signature	**Date**

7. PRIOR COVERAGE INFORMATION (TO BE COMPLETED BY MEDICAL PPO PLAN PARTICIPANTS ONLY)

Name of Covered Individual	Coverage Begin Date	Coverage End Date	Insurance Carrier Providing Coverage

8. BASIC LIFE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE –UHC Life

Employer Paid Life ($15,000) - Beneficiary Designation – ***Primary***			Employer Paid Life ($15,000) - Beneficiary Designation – ***Contingent***		
Name / Relationship	Social Security Number	Percent %	Name / Relationship	Social Security Number	Percent %
Name / Relationship	Social Security Number	Percent %	Name / Relationship	Social Security Number	Percent %

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9. KAISER FOUNDATION HEALTHPLAN ARBITRATION AGREEMENT – SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN- READ CAREFULLY

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

Signature	**Date**

10. UNITED HEALTHCARE ARBITRATION DISCLOSURE – SIGNATURE REQUIRED FOR UNITED HEALTHCARE MEMBERSHIP – READ CAREFULLY

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.
NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
EFFECTIVE DATE: The effective date of coverage is subject to UNITED HEALTHCARE approval.
REQUIREMENT FOR BINDING ARBITRATION
I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

11. Authorization to Release Medical Information and Signature

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. **Please maintain a copy of this authorization for your records.**

Signature	**Date**

12. EMPLOYER AUTHORIZATION – SIGNATURE REQUIRED

I wish to make the choices indicated on this form and authorize ABS to make any necessary pre-tax or after-tax deductions for the plan year. I understand that these elections are from September 1, 2011 through August 31, 2012. I understand that pre-tax contributions will slightly impact my social security contributions. Should I elect to not have these deductions taken pre-tax I will contact Human Resources. I certify that the information on this form is complete and accurate. If it is determined that I have falsified information on this Enrollment Form it could be considered grounds for coverage termination as well as grounds for termination of my employment. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may change. I understand that I may change my elections due to a qualified status change and if changes happen during the year, I must notify Human Resources within 31 days of the qualified status change. I understand that a copy of this form will be made available at my request.

Signature	**Date**