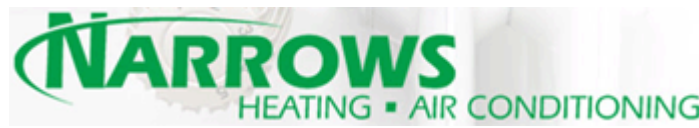




# MADDOCK & ASSOCIATES

creative solutions • continuous service

## Employee Benefits Packet For



Enclosed is an outline of the employee benefit program brought to you by Narrows Heating & Air Conditioning and Maddock & Associates. The purpose of this packet is to give you a brief overview of the plans and assist you with enrollment. Maddock & Associates is your insurance advocate. Please call us at 800-875-4490 with your questions or benefits issues. We are here to help you! Your plan provides

- Medical & Prescription Drugs
- Dental
- Life & AD&D

Detailed benefit summaries and forms are available on-line at:

[www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com)

Login: **nheating** Password: **nheating123**



## **NARROWS HEATING EMPLOYEE BENEFITS ENROLLMENT**

Your employer is pleased to offer you group medical, dental and life insurance coverage. The purpose of this packet is to outline the plans, to advise you of the costs and to assist you with the enrollment. The required forms are attached. Below is a brief description of your plans. For full benefits and limitations please refer to the attached summaries. You will also have 24-hour access to detailed plan summaries, provider directories, and important forms at the Maddock & Associates website, [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com). YourMedicalBenefits LOGIN is **nheating** and your PASSWORD is **heating123**.

### **ENROLLMENT FORMS**

*Anyone not enrolling at this time will **NOT** be eligible to enroll until November 1, 2012 (enrollment forms and health statements must be received by October 31, 2012) unless they meet certain specific requirements, such as involuntary loss of other coverage through a spouse's employer, and apply immediately upon losing such coverage.*

- **AWB Enrollment Form** (Medical & Life)
- **Dearborn Enrollment Form** (Dental)

### **2012/2013 BENEFIT SUMMARY**

**MEDICAL INSURANCE:** Premera Blue Cross through the Association of Washington Business. This plan provides the best benefits when you use Preferred Providers. There is a \$2,500 annual deductible (maximum \$7,500 per family). The deductible is waived for doctor office visits and prescription drugs. Office visits are covered at 100% after a \$30 co-pay. For other services, the plan pays 80% after the deductible for services provided by Preferred physicians and Preferred hospitals. Non preferred, providers are covered at 50% after a \$5,000 deductible. Preferred providers can be found in the provider directory section of your website, [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com), or at [www.premera.com](http://www.premera.com). Click on the Heritage Network.

**PRESCRIPTION DRUGS:** Prescription Drugs are covered at a \$15 co-pay for Generic drugs, \$30 for Preferred Brand drugs and \$50 for Non Preferred Brand drugs. The Premera drug formulary can be found at [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com), or [www.premera.com](http://www.premera.com).

**VISION EXAM & HARDWARE DISCOUNT:** Vision Service Plan. Your plan pays for one eye exam through a VSP doctor after a \$10 co-pay. Hardware is not a covered benefit, but you will receive a discount on hardware through your VSP doctor. To receive this benefit you must go to a VSP provider, not Premera. You will find a list of VSP providers at [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com), or at [www.vsp.com](http://www.vsp.com).

**DENTAL INSURANCE:** Dearborn National. This plan covers preventive care at 100%, basic at 80% and major at 50%. If you use a PPO dentists, basic benefits are increased to 90% and major benefits are increased to 60%. There is a calendar year deductible of \$50 per person which is waived for preventive benefits. The annual maximum is \$1,500 per year. Dearborn National pays at the 90th percentile of usual and customary charges for all dentists, meaning 90% of Washington Dentists take the scheduled payment as payment in full. If you receive care from their Preferred list of dentists you will receive additional discounts. Preferred dentists can be found at [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com), or [www.dearbornnational.com](http://www.dearbornnational.com).

**SECTION 125 PLAN:** Section 125 of the Internal Revenue Code allows employer to set up a plan that allows you to pay for you and your dependents portion of medical and dental premiums on a tax-free basis. The premium amount is deducted from the payroll before taxes are figured...so you use your money tax-free. A brief summary of how this works is attached. Participation is voluntary. All employees will be automatically enrolled in the Section 125 plan. If you do not wish to have your dependent premiums taken on a pre-tax basis, you must notify your plan administrator within 30 days of the date you are eligible.

**LIFE INSURANCE:** Lifewise Assurance. Each employee enrolled in the medical plan will also receive \$15,000 of group life and accidental death & dismemberment insurance. This policy pays \$30,000 if death results from an accident.

**COSTS:** Narrows Heating & Air Conditioning will contribute 100% of the employee rate and 50% of the dependent rate.. The payroll deductions for the remainder of the dependent premiums are below. *(The Child(ren) rates includes all unmarried dependent children to age 26.*

	<b>MEDICAL</b>		<b>DENTAL</b>		<b>TOTAL</b>	
	<b>Semi Monthly Deduction</b>		<b>Semi Monthly Deduction</b>		<b>Semi Monthly Deduction</b>	
	<b>Company Pays</b>	<b>Employee Pays</b>	<b>Company Pays</b>	<b>Employee Pays</b>	<b>Company Pays</b>	<b>Employee Pays</b>
<b>Employee</b>	\$134.86	<b>\$0.00</b>	\$24.71	<b>\$0.00</b>	\$159.57	<b>\$0.00</b>
<b>Emp +Spouse</b>	\$216.49	<b>\$81.63</b>	\$37.07	<b>\$12.36</b>	\$253.55	<b>\$93.99</b>
<b>Emp,Spouse+Child(ren)</b>	\$278.85	<b>\$144.00</b>	\$48.25	<b>\$23.54</b>	\$327.10	<b>\$167.54</b>
<b>Emp + Child(ren)</b>	\$197.10	<b>\$62.25</b>	\$34.56	<b>\$9.85</b>	\$231.66	<b>\$72.10</b>

**FOR FURTHER INFORMATION** feel free to contact any of the following:

Gretchen Svinth.....(253) 627-7543  
Narrows Heating Benefits Website.....[www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com)  
Maddock & Associates.....(800) 875-4490  
Maddock & Associates Website.....[www.medicalbenefits.com](http://www.medicalbenefits.com)  
Premera Blue Cross Claims .....(800)-722-5561  
Premera Website.....[www.premera.com](http://www.premera.com)  
Dearborn National.....(800) 721-7987  
Dearborn National Website.....[www.dearbornnational.com](http://www.dearbornnational.com)

# Premera Blue Cross: AWB Plan D 2500 \$2,500 Deductible

## Grandfathered/Non-Grandfathered

Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: For plans renewing on or after 10/1/2012

Coverage for: Individual or Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.awbhealthchoice.com](http://www.awbhealthchoice.com) or by calling 1-800-722-1471.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network: <b>\$2,500</b> individual / <b>\$7,500</b> family Out-of-network <b>\$5,000</b> individual/ <b>\$15,000</b> family Doesn't apply to in-network preventive care and pharmacy.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You must pay all of the costs for these services up to the specific <b><u>deductible</u></b> amount before this plan begins to pay for these services.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. In-network: <b>\$7,500</b> individual/ <b>\$22,500</b> family Out-of-network: None	The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premium, balance-billed charges, copays, pharmacy, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. For a list of <b>in-network providers</b> , see <a href="http://www.premera.com">www.premera.com</a> or call 1-800-722-1471.	If you use an in-network doctor or other health care <b><u>provider</u></b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No. You don't need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b><u>excluded services</u></b> .

**Questions:** Call 1-800-722-1471 or TDD/TTY 1-800-842-5357 or visit us at [www.awbhealthchoice.com](http://www.awbhealthchoice.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-722-1471 or TDD/TTY 1-800-842-5357 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copay	50% coinsurance	_____none_____
	Specialist visit	\$30 copay	50% coinsurance	_____none_____
	Other practitioner office visit	\$30 copay	50% coinsurance	Spinal manipulations limited to 12 visits PCY, acupuncture limited to 12 visits PCY
	Preventive care/screening/immunization	No charge	Not Covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	_____none_____
If you need drugs to treat your illness or condition	Generic drugs	\$15 copay	\$15 copay and 40% coinsurance	_____none_____
	Preferred brand drugs	\$30 copay	\$30 copay and 40% coinsurance	_____none_____
More information about <b>prescription</b>	Non-preferred brand drugs	\$50 copay	\$50 copay and 40% coinsurance	_____none_____

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<b><u>drug coverage</u></b> is available at <a href="http://www.premera.com">www.premera.com</a> .	Specialty drugs	\$15 copay \$30 copay \$50 copay	\$15 copay and 40% coinsurance \$30 copay and 40% coinsurance \$50 copay and 40% coinsurance	_____none_____
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	50% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	\$100 copay and 20% coinsurance	\$100 copay and 20% coinsurance	_____none_____
	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____
	Urgent care	\$30 copay	50% coinsurance	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	20% coinsurance	50% coinsurance	_____none_____
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	_____none_____
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse
<b>If you need help recovering or have other special health</b>	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits PCY
	Rehabilitation services	\$30 copay (outpatient) 20% coinsurance (inpatient)	50% coinsurance	Limited to 45 outpatient visits PCY, limited to 30 inpatient days PCY

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<b>needs</b>	Habilitation services	Not covered	Not covered	_____none_____
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days PCY
	Durable medical equipment	20% coinsurance	50% coinsurance	_____none_____
	Hospice service	20% coinsurance	50% coinsurance	Limited to 10 inpatient days, 240 respite hours - 6 month overall benefit limit
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

### Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <b>excluded services</b> .)			
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (or other spinal manipulations)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	



## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-722-1471. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Premiera Blue Cross Customer Service at 1-800-722-1471, or you can contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). In addition, you can contact the Washington Consumer Assistance Program at 1-800-562-6900.

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## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-722-1471.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-722-1471.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$3,820
- Patient pays: \$3,720

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,500
Copays	\$20
Coinsurance	\$1,000
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,720</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays 3,020
- Patient pays \$2,380

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,400
Copays	\$900
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,380</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-722-1471 or visit us at [www.awbhealthchoice.com](http://www.awbhealthchoice.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-722-1471 to request a copy.



## Vision Service Plan Benefits Summary Exam Plus Plan

Benefits	Services from a VSP Doctor	Services from an Out-of-Network Provider
<b>Exam</b>	Covered in full after \$10 copayment Once every 12 months	Up to \$42 Once every 12 months
<b>Discount Benefits</b>	<b>Services from a VSP Doctor</b>	<b>Services from an Out-of-Network Provider</b>
<b>Prescription Glasses</b> <ul style="list-style-type: none"> <li>Complete Pairs of</li> </ul>	20 percent discount	Not Applicable
<ul style="list-style-type: none"> <li>Contact Lens Evaluation &amp; Fitting</li> </ul>	15 percent discount off professional fees (evaluation & fitting)	Not Applicable

The primary purpose of this VSP vision care plan is to provide professional eye exams and material discounts to help pay the cost of materials. When obtaining services from a VSP doctor, the exam is covered in full, less any applicable copayment. Members receive a 20 percent discount off the VSP doctor's usual and customary fees for complete pairs of prescription glasses. The discount includes lenses and lens characteristics chosen for cosmetic reasons. A 15 percent discount applies to the doctor's professional services for all types of prescription contact lenses. This discount applies to professional services only, materials are provided at usual and customary fees.

**Obtaining services from a VSP doctor:** When you want to obtain vision care services, call a VSP doctor to make an appointment. *For details on how you locate a VSP doctor, contact your benefits representative, call VSP at 800-877-7195 to request a VSP doctor list or go to [vsp.com](http://vsp.com).* **Make sure you identify yourself as a VSP member and be prepared to provide the covered member's social security number.** The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you. VSP will pay the doctor directly for covered services and materials.

**Obtaining services from an out-of-network provider:** Services obtained from an out-of-network provider will be reimbursed up to amount on the above schedule less any copayment. For out-of-network reimbursement, pay the entire bill when you receive services, then send your itemized receipts and full patient and member information to VSP. Claims must be submitted to VSP within six months from your date of service. Please keep a copy of the information for your records and send the originals to the following address: Vision Service Plan, Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

**ADDITIONAL BENEFITS: Laser Vision Correction:** VSP's Laser VisionCare™ program is also available to those covered under this VSP WellVision® Plan. It is designed to provide members with a discount off laser surgery when obtained through VSP contracted doctors, surgeons, and laser centers. Call your VSP doctor to check if he or she is participating in the program. Doctors can also be located on VSP's Web site at [vsp.com](http://vsp.com) or by calling 888-354-4434.

When an exam is received from a VSP doctor, the patient will have no out-of-pocket expense other than the copayment.

THIS IS ONLY A SUMMARY  
FOR FURTHER INFORMATION, SEE YOUR EMPLOYER'S BENEFIT REPRESENTATIVE  
VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195  
Visit our Web site at [vsp.com](http://vsp.com)

## **Using VSP – Exceptional Member Service**

### ***Our Promise to You and Our Members***

At VSP, we strive to deliver the kind of personalized care and exceptional service we'd expect for ourselves. That's why we've instituted a promise to our members that guarantees their satisfaction. We know that satisfied members lead to satisfied clients. And by providing you with the knowledge that we are taking good care of your members, you can focus your valuable resources elsewhere.

Our promise is this: If at any time VSP members are not completely satisfied with their eyecare services or their eyewear, they can just let us know, and we'll make it right.

### ***Did You Know?***

- 93% of VSP patients visit VSP's doctors
- 84% of VSP doctors offer morning, evening and/or weekend hours.

### ***Using the VSP Benefit, Easy as 1, 2, 3***

VSP members just:

1. Consult benefit information for coverage details.
2. Find a VSP doctor online or by phone 24 hours a day.
3. Make an appointment with a VSP doctor, identifying himself/herself as a VSP member.

It's that simple! The VSP doctor will take care of the rest.

In addition, although most VSP members receive services from VSP doctors, members may choose to see an out-of-network provider. However, when members visit a VSP network doctor, benefits are greater, and they are covered by VSP's Member Promise, guaranteeing their satisfaction.

***"Highest in Overall  
Member Satisfaction  
Among National  
Vision Plans."***

2004 National Vision Plan Member Satisfaction Study. Study based on 766 respondents who are members of large national vision care plans. Study conducted for VSP by J.D. Power and Associates.



## Life and AD&D Benefit Summary

This summary of benefits explains the key features of the Group Life and AD&D benefits. The contract between LifeWise Assurance Company and the Association of Washington Business, and the benefit booklet set out the actual terms, conditions and exclusions of coverage. This summary of benefits is not a contract.

Benefit Amount	
Eligible Employees	
Evidence of Insurability	
Benefit Reduction	The Life and AD&D benefits reduce to 65% at age 65, reduce to 50% at age 70 reduce to 30% at age 75, further reduce to 20% at age 80 and terminate at retirement.
Life Provisions	
Conversion	If all or part of the life insurance ends, the insured may convert the life insurance to an individual life policy without evidence of insurability. The maximum amount that can be converted is the amount the insured is eligible for at the time the coverage ends. The insured may convert a lower amount of life insurance. In order to convert to an individual policy, the insured must submit a written application and pay the first month's premium within 31 days after the group life insurance ends.
Waiver of Premium	If the employee becomes disabled, we will waive the life insurance premium on the basic life insurance. If the employee has dependent life insurance, the premiums for the dependent will be waived as well. The employee must become disabled prior to his or her 60 <sup>th</sup> birthday while insured under the life insurance policy and must remain continuously disabled for six months. The employee must submit a waiver of premium application and be approved for this waiver to apply. Disability waiver of premium for the life insurance will end when the employee is no longer disabled, when the employee fails to provide proof of disability or when the employee attains age 65.
Accelerated Benefit	An accelerated benefit is an advance payment before death of a part of the life insurance benefit. If the employee qualifies for an accelerated benefit, up to 75% of the basic life benefit in force is payable. If an accelerated benefit is paid, the life insurance benefit otherwise payable to the named beneficiary will be reduced by the sum of the accelerate benefit. The premiums for the full amount of the benefit in force before the payment of the accelerated benefit must be paid until the employee ceases active work. At that time, the premiums will be waived.

## Life and AD&D Benefit Summary

AD&D Benefit	
The amount of the AD&D benefit payable is determined by the severity of the loss. If the employee is injured or dies as the result of an accident, the AD&D benefit payable will equal the amount of the employee's basic life insurance based on the following schedule:	
Loss	Percent of AD&D benefit
Life	100%
Quadriplegia	100%
Speech and hearing	100%
Both hands, both feet, sight of both eyes or any combination thereof	100%
One hand, one foot, or sight of one eye	50%
Hemiplegia	50%
Paraplegia	50%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Loss of more than one of the above in any one accident	100%
AD&D Provisions	
Seat Belt	If the employee was wearing the seat belt and dies in an automobile accident while riding or driving in a private passenger automobile, we will pay a benefit in addition to the AD&D benefit. The additional benefit will be 10,000.
Exclusions	<p>The AD&amp;D benefits will not be paid for losses that result from:</p> <ul style="list-style-type: none"> <li>• disease or bodily or mental infirmity, or medical treatment of such condition;</li> <li>• ptomaine or bacterial infection except for infections occurring through an accidental cut or wound</li> <li>• participation in a riot;</li> <li>• suicide, or its attempt, while sane or insane,</li> <li>• intentionally self inflicted injuries;</li> <li>• war or any act of war that is declared or undeclared; or</li> <li>• attempt or commission of an assault or felony under state law</li> </ul>

## Life and AD&D Benefit Summary

Life and AD&D Definitions	
Accident	A sudden and unforeseen event, definite as to time and place.
Active Work or Actively At Work	<p>The performance of the regular duties of an employee's work for the policyholder on a full-time basis. Such work must be performed:</p> <ol style="list-style-type: none"> <li>1. at the employee's usual place of employment or as required by the policyholder; and</li> <li>2. for not less than the minimum number of hours specified in the Schedule.</li> </ol> <p>An employee will be deemed to be actively working on a full-time basis on:</p> <ol style="list-style-type: none"> <li>1. regularly paid vacation; and</li> <li>2. regular non-work days on which the employee is not disabled,</li> </ol> <p>if the employee was at active work on a full-time basis on the last preceding regular work day.</p>
Beneficiary	The person or entity to whom benefits for loss of life are payable.
Disabled or Disability	Refers to any disability which results from a sickness or injury that completely prevents the employee from engaging in any occupation for wage or profit for which the employee is or becomes reasonably qualified due to education, training, or experience.
Injury	Bodily injury which is caused by an accident and which results directly from the accident and independently of all other causes.
Loss	<p>With regards to the AD&amp;D Insurance means:</p> <ul style="list-style-type: none"> <li>• To the hand or foot", the actual severance of a hand or foot at or above the wrist or ankle joint. Loss does not mean the loss of function of a hand or foot due to injury. Severance" means the complete amputation of a hand or foot at or above the wrist or ankle joint.</li> <li>• To the thumb and index finger, the actual severance of the thumb below the thumb joint and below the second joint of the index finger. Loss does not mean the loss of function of the thumb and index finger due to injury.</li> <li>• Loss of an eye means the total and irrecoverable loss of sight.</li> <li>• Loss of speech means total and irrecoverable loss of audible communication.</li> <li>• Loss of hearing means permanent total deafness in both ears such that it cannot be correct to any functional degree by any aid or device.</li> <li>• Quadriplegia means complete and irreversible loss of the use (paralysis) of both upper and both lower limbs</li> <li>• Paraplegia means complete and irreversible loss of the use (paralysis) of both lower limbs</li> <li>• Hemiplegia means complete and irreversible loss of the use (paralysis) of the upper and lower limbs on one side of the body.</li> </ul>



# 24-Hour NurseLine

Because your healthcare needs don't have a schedule, we offer peace of mind to members with round-the-clock access to the Premera Blue Cross Blue Shield of Alaska 24-Hour NurseLine

The 24-Hour NurseLine is fast, free, confidential and available any time, any day.



## Helpful information

Nurses will listen to your concerns, answer your questions and offer advice about many health-related topics.

Their healthcare advice can help you to understand and better manage your condition, as well as provide peace of mind about what to expect or do about your health condition.


## Helping you know where and when to seek care

Nurses are trained to ask the right questions, listen to your concerns, and help you determine where and when to seek treatment for an injury or illness. The nurse provides healthcare advice based on your symptoms and other relevant health conditions or history.

## FREE and CONFIDENTIAL

All calls to the 24-Hour NurseLine are free, confidential and available 24 hours a day, 7 days a week. Call 800-841-8343.






**24-Hour NurseLine**

*Speak with a registered nurse about your non emergency healthcare concerns*

**800-841-8343**

In case of an emergency, CALL 911

**PREMERA** |   
**BLUE CROSS BLUE SHIELD OF ALASKA**

*The 24-Hour NurseLine is NOT a substitute for regular, scheduled care from your physician or healthcare provider.*



**We know the territory.**



## Benefit Highlight Sheet for: **NARROWS HEATING & AIR CONDITIONING, INC.**

The following is a listing of common services available through the DNoA Preferred Dental Network. The member's share of the costs depends on whether care is received from a participating or non-participating provider.

Benefits	Participating Provider	Non-Participating Provider
<b>Calendar Year Maximum</b>	\$1,500	
<b>Deductible</b>	\$50 per person per Calendar year. \$150 maximum per family <i>(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)</i>	\$50 per person per Calendar year. \$150 maximum per family <i>(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)</i>
<b>Dependent Coverage</b>	Spouse and unmarried dependent up to age 19 or unmarried full-time student up to age 25	
<b>Diagnostic and Preventive Services</b> Oral Exams, X-rays, Professional Cleanings, Fluoride Treatment	100 % of Maximum Allowance*	100% of Reasonable and Customary Charges**
<b>Miscellaneous Services</b> Sealants (per tooth), Space Maintainers, Pulp Vitality Tests, Palliative Treatment to relieve dental pain	100% of Maximum Allowance*	100% of Reasonable and Customary Charges**
<b>Restorative Services</b> Amalgam filling, Pin Retention (per tooth), Composite Restorations, Tooth Extraction	90% of Maximum Allowance*	80% of Reasonable and Customary Charges**
<b>General Services</b> Intravenous Sedation, General Anesthesia, Stainless Steel Crowns, House Call, Injection of Antibiotic Drugs	90% of Maximum Allowance*	80% of Reasonable and Customary Charges**
<b>Endodontic Services</b> Molar Root Canal Therapy, Bicuspid Root Canal Therapy	90% of Maximum Allowance*	80% of Reasonable and Customary Charges**
<b>Periodontal Services</b> Scaling & Root Planing (per quadrant), Osseous Surgery (per quadrant)	90% of Maximum Allowance*	80% of Reasonable And Customary Charges**
<b>Oral Surgery Services</b> Surgical Tooth Extractions, Other dentally necessary surgical procedures	90% of Maximum Allowance*	80% of Reasonable And Customary Charges**
<b>Crown/Inlay/Onlay Services</b> Prefabricated Post and Cores, Crown, inlays/ onlays Repairs	60% of Maximum Allowance*	50% of Reasonable And Customary Charges**
<b>Prosthodontic Services</b> Bridgework, Dentures	60% of Maximum Allowance*	50% of Reasonable And Customary Charges**

**Please note:** This information is only a product highlight. Products underwritten and services provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam are marketed under the Dearborn National™ brand and the star logo. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

\* Maximum Allowance means the amount determined by Fort Dearborn Life which providers have agreed to accept a payment in full for a particular service.

\*\* For services received from a non-participating provider, you will be liable for any difference between the dentist's charge and your covered benefits.

# SECTION 125 PREMIUM PLAN

Here's how it works:

This employee enrolled his eligible dependents on the medical plan (\$195.00 per month for his spouse and \$135.00 for the children). As you can see, he avoided paying taxes on the premiums he paid...and his spendable income increased.

**ANNUAL SALARY: \$30,000 MARITAL STATUS: Married**

	<b>Before</b> Section 125 Plan	<b>After</b> Section 125 Plan
Annual Salary	\$30,000.00	\$30,000.00
Salary Reductions		
Health Insurance Premiums	0.00	\$3,960.00
Taxable Income	\$30,000.00	\$26,040.00
Payroll Taxes		
7.65% FICA (fixed)	2,295.00	1,992.06
15% Federal Tax (variable)**	4,500.00	3,906.00
Total Taxes	6,795.00	5,898.06
After-Tax Pay	23,205.00	20,141.94
After-Tax Expenses		
Health Insurance Premiums	3,960.00	0.00
Actual Spendable Income	\$19,245.00	\$20,141.94

**Annual Increase in Take-Home Pay: \$896.94**

\*\* Federal Income Tax savings will vary based on your income and personal tax situation. In most cases, individual income taxes are higher than 15% and savings are more.

\*\*\*Participation in the Section 125 Premium Only Plan is optional. Since it decreases the amount of Social Security taxes you pay, those nearing retirement may wish to evaluate the impact of their participation with a representative of the Social Security Administration.\*\*\*

\*\*\*Premiums for dependents covered on your medical plan who are not IRS dependents (i.e. domestic partners or children over age 19 who are not living with you) cannot be included in a Section 125 Premium Only Plan. Please advise your HR department if you have this situation.\*\*\*

# NARROWS HEATING & AIR CONDITIONING, INC.EMPLOYEE BENEFITS BENEFITS, COMPLIANCE & NOTIFICATION SHEET

Below is a list of rights and notices that apply to you through the Narrows Heating & Air Condition, Inc. Employee Benefit plan. Please visit [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com) to download details about this important information. The log in and password are on the first page of this packet. Paper copies are available upon request from your HR department.

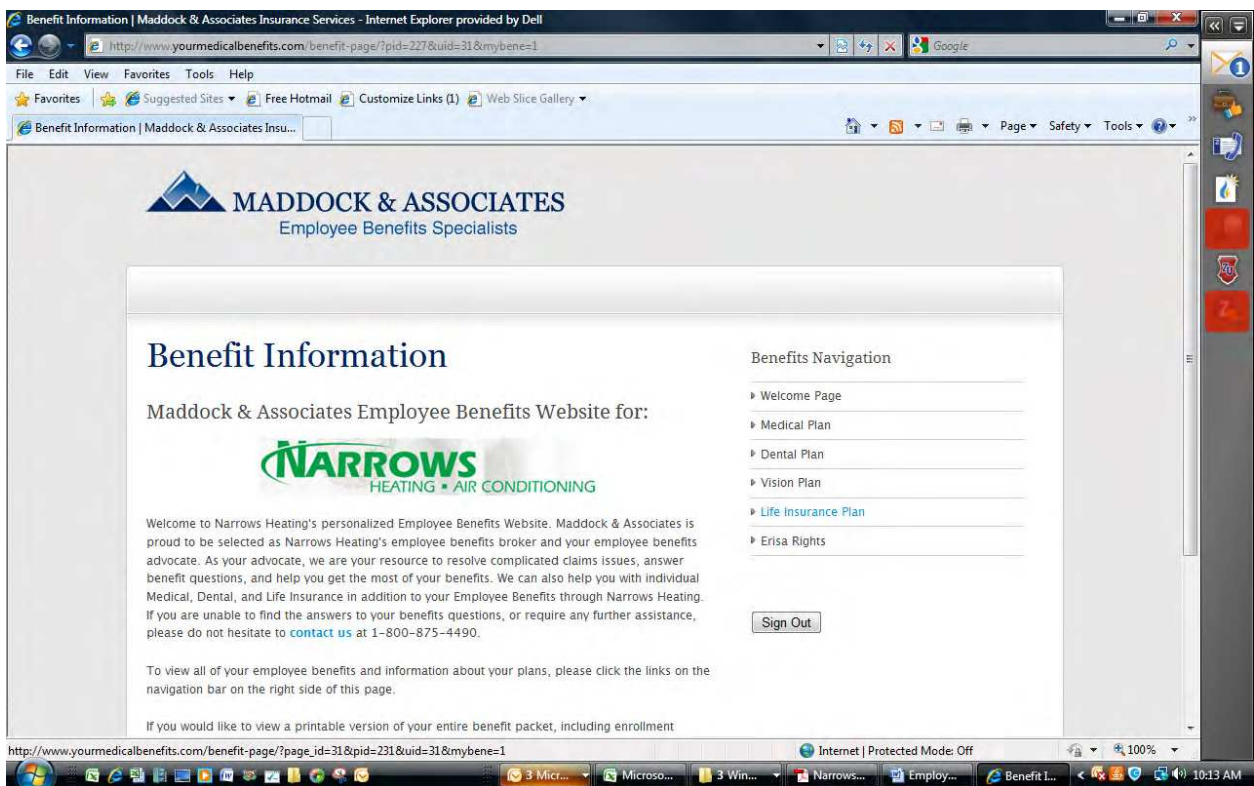
1. Erisa Summary Plan Description
2. Cobra Notice
3. Medicare Credible Coverage Notice
4. Section 125 Premium Reduction Plan Explanation of Benefits
5. HIPAA Special Enrollment Rights Notice
6. HIPAA Preexisting Condition Exclusion Notice
7. Uniform Services Employment and Reemployment Rights Act Notice
8. Women's Health and Cancer Rights Act Notice

## Your Employee Benefits Website

At Maddock & Associates we do everything possible to provide added value to all our clients. Our ability to offer our clients the best service possible has made us one of the top brokers in Washington State. Our latest value added service is on the Internet at [www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com). Each one of our clients receives a custom employee benefits website to keep their employees informed of their employee benefits.

Benefits of the website include:

- Employees have one place to find information about all their insurance plans, from any computer, 24 hours a day.
- Employees have instant access to on-line provider directories, employment change forms, and claim forms.
- Benefit administrators spend less time dealing with insurance issues.



[www.yourmedicalbenefits.com](http://www.yourmedicalbenefits.com)

UserName = nheating

PassWord = nheating123

# Employee Enrollment/Change Form

<b>EMPLOYER NAME</b>		<b>EMPLOYER NUMBER</b>	
<b>ENROLLMENT</b> Requested Effective Date: ____ / 01 / 201____ Employee Date of Hire: ____ / ____ / ____ <i>Please check appropriate box:</i> <input type="checkbox"/> New employee <input type="checkbox"/> New employee & dependent(s) <input type="checkbox"/> New dependent(s) (Please specify qualifying event at right) <input type="checkbox"/> Entered Eligible Class Date ____ / ____ / ____		<b>QUALIFYING EVENT FOR SPECIAL ENROLLMENT</b> <i>Please check box below:</i> <input type="checkbox"/> Marriage/Domestic Partnership (Affidavit Required) <b>Date of marriage/partnership</b> ____ / ____ / ____ <input type="checkbox"/> Involuntary Loss of Coverage <input type="checkbox"/> Adoption/Legal Guardian ( <i>Legal documentation required</i> ) <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Death	
		<b>CHANGE</b> <i>Please check box below:</i> <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Delete Employee(s) Effective date ____ / ____ / ____ <input type="checkbox"/> COBRA / Continuation Coverage Start date ____ / 01 / 20____	

<b>LINCOLN FINANCIAL GROUP VOLUNTARY BENEFITS</b>					<b>DENTAL PLAN SELECTION</b> If your Employer is enrolling 5 or more Employees and is choosing a Dental product you're responsible for selecting the carrier of your choice. If you have any questions your employer will gladly assist you during the enrollment process  <input type="checkbox"/> Premera DentalBlue <input type="checkbox"/> Willamette Dental		
<b>Voluntary Life</b>			<b>Short Term Disability Buy-up</b>				<b>Long Term Disability Buy-Up</b>
Employee	Spouse	Dependent Child(ren)	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$25,000.00 <input type="checkbox"/> \$50,000.00 <input type="checkbox"/> \$75,000.00 <input type="checkbox"/> \$100,000.00	<input type="checkbox"/> \$10,000.00 <input type="checkbox"/> \$20,000.00 <input type="checkbox"/> \$30,000.00 Spouse coverage must be 50% or less of the employee choice	<input type="checkbox"/> \$10,000.00	\$500 Weekly benefit, 3/6 pre-ex limitations on buy up amount only				Buy up benefit is limited to 60% of employee salary, up to \$5000 Monthly benefit has a 3/12 pre-existing limitation on base and buy-up plans.
Rates & benefit reduce by age			Buy-up only available if your employer has purchased the base coverage				
For more details please refer to the benefit summaries. <i>Please check with your producer or group administrator for your eligibility.</i>							

<b>EMPLOYEE INFORMATION</b>						
Last Name		First Name		M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____ / ____ / ____
Mailing Address			Apt #	City, State, Zip		
Social Security Number ____ - ____ - ____		Home Phone ( ____ ) ____ - ____		Work Phone ( ____ ) ____ - ____		Email
<b>Are you covered by workers' compensation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exempt				<b>Current Job Title</b>		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership (Affidavit or State Registration Required)						
Prior Coverage <input type="checkbox"/> YES <input type="checkbox"/> NO		Insurance Carrier:		Start date of prior coverage : ____ / ____ / ____      End date of prior coverage: ____ / ____ / ____		

<b>DEPENDENT INFORMATION</b> (Please check the add or delete box for each enrollee)						
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name	
			Social Security Number ____ - ____ - ____		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____ / ____ / ____
			Previous coverage- HIPAA:   Prior carrier:		Start date of prior coverage: ____ / ____ / ____	Prior coverage ended: ____ / ____ / ____
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name	
			Social Security Number ____ - ____ - ____		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____ / ____ / ____
			Previous coverage- HIPAA:   Prior carrier:		Start date of prior coverage: ____ / ____ / ____	Prior coverage ended: ____ / ____ / ____

# Employee Enrollment/Change Form



EMPLOYER NAME

EMPLOYER NUMBER

## DEPENDENT INFORMATION CONTINUED (Please check the add or delete box for each enrollee)

Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name		
			Social Security Number      -      -		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth      /      /	
			Previous coverage- HIPAA:    Prior carrier:		Start date of prior coverage:      /      /		Prior coverage ended:      /      /
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name		
			Social Security Number      -      -		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth      /      /	
			Previous coverage- HIPAA:    Prior carrier:		Start date of prior coverage:      /      /		Prior coverage ended:      /      /
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name		
			Social Security Number      -      -		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth      /      /	
			Previous coverage- HIPAA:    Prior carrier:		Start date of prior coverage:      /      /		Prior coverage ended:      /      /
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name		First Name		
			Social Security Number      -      -		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth      /      /	
			Previous coverage- HIPAA:    Prior carrier:		Start date of prior coverage:      /      /		Prior coverage ended:      /      /

## BENEFICIARY FOR EMPLOYEE'S LIFE INSURANCE BENEFIT

Beneficiary Name	Beneficiary Address	Relationship to employee
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### APPLICANT / HIPAA ACKNOWLEDGEMENT

I am an active full-time employee or owner regularly working at least 20 hours per week. All information given by me on this form is true and complete. My signature below attests that the prior coverage data provided above is complete and accurate to the best of my knowledge, and can be documented upon request with evidence of coverage from my, and my dependent's, prior plan(s). I authorize the Association of Washington Business to obtain information from third parties regarding any matters that may bear on this application.

I understand that AWB HealthChoice and the insurance carriers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out its routine business functions, which include, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting and conducting case management, care management and quality reviews. AWB HealthChoice and the insurance carriers may also disclose protected health information to state and federal agencies or other third parties as required or permitted by law.

### FRAUD WARNING STATEMENT

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Any person who knowingly and with intent to defraud a health care service contractor or any other person files a request for benefit coverage 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 act which may result in the denial of health care coverage or insurance coverage.

**This application must be signed**

**Applicant Signature** \_\_\_\_\_

*Please return this form to your employer*

**Date** \_\_\_\_\_

#### Underwritten by:

Premera Blue Cross  
7001 220th SW  
Mountlake Terrace, WA 98043

Lincoln Financial Group  
8801 Indian Hills Drive  
Omaha, NE 68114

LifeWise Assurance Company  
7007 - 220th SW  
Mountlake Terrace, WA 98043

Premera DentalBlue  
7001 220th SW  
Mountlake Terrace, WA 98043

Vision Service Plan (VSP)  
600 University St Ste 2004  
Seattle, WA 98101

Willamette Dental of Washington, Inc.  
181 S 333rd St Suite C-100  
Federal Way, WA 98003



☐ New Enrollment    ☐ Change    ☐ Open Enrollment    ☐ COBRA    ☐ Retiree

## Employer/ Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER		GROUP NO. / ACCOUNT NUMBER		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.		EARNINGS \$ Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/>		JOB TITLE	CLASS
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE		WORK PHONE		CELL PHONE	

## BENEFIT SELECTION - DENTAL

<b>INITIAL ENROLLMENT</b> Spouse includes Domestic Partner. <i>(Choose One.)</i> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<b>POLICY CHANGE</b> <i>(Check Reason for Change.)</i> <input type="checkbox"/> Married <input type="checkbox"/> Birth / Adoption <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Address Change	<b>CANCEL COVERAGE</b> <input type="checkbox"/> Terminate Coverage Date: ____/____/____ <input type="checkbox"/> Leave / Lay Off <input type="checkbox"/> Other Date: ____/____/____
<b>COBRA CONTINUATION PRIVILEGE</b> Start Date: ____/____/____ Projected End Date: ____/____/____		
<i>Previously covered with group as:</i> <input type="checkbox"/> 1. Employee (termination, reduction in hours, other.) <input type="checkbox"/> 2. Spouse (divorce from employee, death of employee.) <input type="checkbox"/> 3. Dependent (reached age limit, married, no longer a Full Time Student, other.) <input type="checkbox"/> 4. Spouse & Dependents (Divorce from employee, death of employee, other.)		

## Covered Spouse and Dependents: Dependent Child(ren) over the age 26 indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name	Last Name	Social Security Number	Date of Birth	Relationship	Sex Male-Female	Adult Child FTS or HDCP	Name of Accredited School
				<b>SPOUSE</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
Is your spouse covered under any other dental plan? <input type="checkbox"/> Y <input type="checkbox"/> N				If Yes, carrier's name:			
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. I UNDERSTAND THAT IF I DO NOT REMAIN ACTIVELY AT WORK THAT MY COVERAGE MAY LAPSE OR TERMINATE. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

FOR FDL USE ONLY

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

### Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**The laws of some states require us to furnish you with the following notice:**

**FOR CLAIMS ONLY:**

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** 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.

**California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FOR APPLICATIONS ONLY:**

**Massachusetts:** 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.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.