Insperity

BENEFITS ENROLLMENT / CHANGE REQUEST

Plan Year 2012

Please print legibly.

INTERNAL USE ONLY	Insperity Client No.	Client Waiting Period	Coverage Effective Date

INSTRUCTIONS

You must enroll to participate	**There is no automatic enrollment or participation in the Insperity Group Health Plan (Plan).** To enroll for Plan benefits or to request an election change, **complete all applicable sections of this form, read the Terms of Participation and sign and date on page 4,** and timely return the completed original form as directed.
You must enroll on time	To enroll you and provide group health and associated welfare benefits that are tied to an election of medical coverage, Insperity must receive your properly completed Benefits Enrollment/Change Request: • **Within 30 days** (or any longer period as required under state insurance law that applies to your coverage) of your becoming eligible or experiencing a mid-year election change event), OR • **By the last day** of your open enrollment period (as applicable).
Waiving coverage	If you do not submit your completed enrollment request to Insperity within 30 days* of eligibility, you automatically waive your Group Health Plan coverage and any associated welfare benefits that are tied to an election of medical coverage. If you waive Group Health Plan coverage, but basic life and personal accident insurance (PAI) coverage is available to you independent of medical coverage enrollment, you should **complete Sections A & B below and Section F on page 5 of this form** (Life Insurance Beneficiary Designation) and return to Insperity as directed. Certain states require individuals who waive group health plan coverage to submit a separate acknowledgment of waived benefits. You must complete and return the appropriate separate state waiver acknowledgment form if you work or live in any of the states indicated by the state-specific forms included in your Insperity employment and benefits enrollment paperwork. (See your Insperity Forms & Policies Book.)

A. Employee Information

(Please complete **ALL** fields in this section except where otherwise noted regarding Employee ID No.)

Please provide only ONE Employee Identification number below. If at all possible, the preferred ID number is your Insperity Employee ID No. (the primary identifier required by Insperity's data system). If you have received an Insperity paycheck, your Insperity Employee ID number appears on your paystub. If you are a new employee and have not yet received your Insperity Employee ID number, please provide a full Social Security No. to facilitate accurate initial identification. Insperity stringently protects the privacy of all personal identification information.

Employee Last Name	Employee First Name	Middle Name or Initial	Insperity Employee ID No. (if available)

OR

Employee Street Address	City	State	ZIP Code	Last 4 Digits of Employee SSN

OR

Home Telephone No.	Work Telephone No.	Marital Status	Date of Birth	Gender	Employee Social Security No.
( )	( )	☐ Married ☐ Single		☐ M ☐ F	_ _ _

B. Enrollment / Change Designation

(First indicate your reason for submitting this form by checking **ENROLL** or **CHANGE** below. Then check the appropriate box under the reason you indicate that describes your enrollment action.)

☐ **ENROLL**

This enrollment is for:

- ☐ **New Employee Enrollment**
- ☐ **Annual Open Enrollment**
- ☐ **Mid-Year Election Enrollment**
  You must validate by providing information about the qualifying mid-year election change event in Section C below.

☐ **Beneficiary Designation for Basic Term Life Insurance**
Complete separate form on p. 5

☐ **CHANGE**

This enrollment change is for:

- ☐ **New Enrollment Revision**
- ☐ **Annual Open Enrollment**
- ☐ **Mid-Year Election Change**
  You must validate by providing information about the qualifying mid-year election change event in Section C below.

☐ **Beneficiary Designation for Basic Term Life Insurance**
Complete separate form on p. 5

CHANGE TO BE MADE (Check all that apply):

For changes indicated below (except termination of coverage), please also provide the corresponding information required in Sections D & E on pp. 2 & 3, and then sign and date the Terms of Participation on p. 4.

- ☐ **Add** a Dependent to your coverage
- ☐ **Remove** a Dependent from your coverage
- ☐ **Change** Medical Coverage Election
- ☐ **Change** Dental / Vision Coverage Election
- ☐ **Terminate All Group Health Plan Coverage**
  Ends ALL coverage for you and all enrolled dependents, including Basic Life, PAI (AD&D) and Basic Disability insurance benefits that may be included in your employee benefits package and tied to an election of medical coverage. Conversion opportunity may apply; contact Insperity at 866-715-3552 for information.

C. Mid-Year Election Change Request

(This section does **NOT** apply to initial benefits enrollment or annual open enrollment.)

Complete this section **ONLY** when requesting a mid-year change in your benefits coverage that is consistent with the election change event you check below. You must submit this change request to Insperity within **30 days*** of the election change event.

1. Please contact Insperity at **866-715-3552** to determine if documentation / proof is required.
2. Check the box below that describes the event that validates this change request.
3. Provide the name(s) of affected family member(s) in Section E (Individuals To Be Covered) on page 3 of this form.

Date of the Election Change Event That Validates This Mid-Year Change Request [mm/dd/yyyy]: / /

☐ **Change in Marital Status:**	☐ Marriage ☐ Legal separation ☐ Divorce or annulment ☐ Death of spouse
☐ **Change in Domestic Partner Status:**	☐ Add domestic partner ☐ Remove domestic partner
☐ **Change in Number of Dependents:**	☐ Birth of dependent ☐ Death of dependent ☐ Adoption or placement for adoption
☐ **Change in Dependent's Eligibility under an Employer's Plan:**	☐ Lost eligibility ☐ Gained eligibility
☐ **Judgment, Decree or Order (QMCSO):**	☐ QMCSO requiring coverage under this Plan
☐ **Change in Employment Status That Affects Eligibility:**	☐ Termination of employment ☐ Change in classification: part-time / seasonal / temporary to full-time ☐ Change in classification: full-time to part-time / seasonal / temporary
☐ **Change in Residence That Affects Eligibility**	
☐ **Entitlement to Medicare or Medicaid**	
☐ **Other Election Change Event Permitted by This Plan**	

D. Health Care Election(s)

For information about the health care coverage options available to you, please refer to **The Benefits Book** you received in your Insperity orientation materials or call Insperity toll-free at **866-715-3552,** weekdays between 7 a.m. and 7 p.m. CT.

Follow the instructions below to elect health care coverage for yourself and any eligible dependents you elect to cover. You (the employee) **MUST** enroll in the Insperity Group Health Plan in order to elect health care coverage for any eligible dependents. Coverage election(s) you indicate below will apply **BOTH** to you and all covered dependents. **You may <u>not</u> elect different coverage for your dependents.**

MEDICAL COVERAGE

To elect medical coverage under the Insperity Group Health Plan, locate the package-level **<u>column</u>** below that corresponds to your Insperity benefits package level. **<u>From the choices available in that column</u>,** indicate your medical coverage election by checking **<u>ONLY ONE BOX</u>**.

If the coverage option you elect below does NOT have an associated network available in your area, you will be enrolled in the closest corresponding coverage option that **is** available in your area. For information on network service areas available to you, please refer to your **Benefits Book** or call Insperity at **866-715-3552.**

CHART ABBREVIATIONS:

CP = Choice Plus | **HDHP** = High Deductible Health Plan | **PPO** = Preferred Provider Organization | **HMO** = Health Maintenance Organization | **POS** = Point of Service.

For each coverage option shown in the table below, the first number indicates the individual in-network calendar-year deductible for that option; the second number is the coinsurance level. For example, "500 / 90%" means the coverage option has a $500 individual in-network calendar-year deductible, and the plan pays 90% coinsurance.

For Eligible Employees . . .	Insurance Carrier	500-Level Pkgs.	1000-Level Pkgs.	1500-Level Pkgs.	HDHP-Level Pkgs.	Value-Level Pkgs.
. . . **NATIONWIDE** (UNLESS a state-specific set of options is listed below)	**UnitedHealthcare**	☐ CP: 500 / 90%	☐ CP: 1000 / 80%	☐ CP: 1500 / 80%		
		☐ CP: 250 / 100%	☐ CP: 500 / 90%	☐ CP: 500 / 90%		
		☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	
		☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%
. . . who live in **CALIFORNIA**	**UnitedHealthcare**		☐ CP: 1000 / 80%	☐ CP: 1500 / 80%		
		☐ CP: 500 / 90%	☐ CP: 500 / 90%	☐ CP: 500 / 90%		
		☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	
		☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%	☐ HDHP: 3000 / 90%
	UnitedHealthcare of California	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%		
	Kaiser Permanente	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%		☐ HMO: 1000 / 100%
	Blue Shield of California	☐ HMO: 0 / 100% *(Northern CA only)*	☐ HMO: 0 / 100% *(Northern CA only)*	☐ HMO: 0 / 100% *(Northern CA only)*		
. . . who live in **MASS. & NH** * *Tufts HMOs available throughout **MA** & limited ZIP code service areas of **NH** that border MA)*	**Tufts Health Plan CareLink Advantage**	☐ PPO: 500 / 90%	☐ PPO: 1000 / 80%	☐ PPO: 1500 / 80%		*Value-Level packages not available in this location.*
		☐ PPO: 250 / 100%	☐ PPO: 500 / 90%	☐ PPO: 500 / 90%		
		☐ HMO*: 0 / 100%	☐ HMO*: 1000 / 100%	☐ HMO*: 1000 / 100%		
		☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	☐ HDHP: 1500 / 90%	
. . . who live in **Dane Cty, WISCONSIN**	**Unity Health Plan**	☐ POS: 250 / 100%	☐ POS 250 / 100%	☐ POS 250 / 100%	*HDHP -Level packages not available in this location.*	*Value-Level packages not available in this location.*
		☐ HMO: 0 / 100%	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%		
. . . who live in **HAWAII**	**UnitedHealthcare**	☐ PPO: 100 / 90%	☐ PPO: 100 / 90%	☐ PPO: 100 / 90%	*HDHP -Level packages not available in this location.*	*Value-Level packages not available in this location.*
	HMSA BCBS of HI	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%		
	Kaiser Permanente	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%	☐ HMO: 0 / 100%		

DENTAL & VISION COVERAGE

Freedom & Independence benefits packages ONLY ▪ ***Liberty benefits packages <u>do not</u> include Dental & Vision coverage.***

If your benefits package includes Dental & Vision coverage, it may be available to you as an **<u>INCLUDED</u>** benefit when you elect medical coverage above, **OR** this coverage may be available to you as a **<u>SEPARATE</u>** benefit that you may elect by itself, **WITHOUT electing medical coverage also.**

Please call Insperity toll-free at **866-715-3552** to determine whether your benefits package includes Dental & Vision coverage, and if so, whether your package allows you to elect Dental & Vision coverage ONLY, without being required to elect medical coverage also. Even if Dental & Vision coverage is included as part of your medical coverage, you should still complete this section of the form by indicating your Dental & Vision coverage election below.

☐ **I elect Dental & Vision coverage, <u>in addition to</u> the medical coverage option I have elected above.**
*Be sure **also** to check a medical coverage group or option from the choices in the Medical Coverage section above.*

☐ **I elect Dental & Vision coverage <u>ONLY</u>, if allowed by my Insperity benefits package.**
IMPORTANT: ***IF** Dental & Vision coverage is available to you as a **<u>SEPARATE</u>** election from medical coverage, and you elect **ONLY** Dental & Vision coverage, **you will be considered to have waived enrollment for medical coverage under the Insperity Group Health Plan, as well as enrollment for certain welfare benefits that may be included in your benefits package and tied to an election of medical coverage** (such as basic term life & PAI /AD&D).*

E. Individuals To Be Covered (Not required if you are waiving or terminating all Plan coverage.)

It is your responsibility and obligation to ensure that all applicable eligibility requirements are satisfied before you enroll a person as your eligible dependent. In addition, if an enrolled dependent loses eligibility under the Plan, you must notify Insperity of such change as soon as possible. Refer to the Insperity Group Health Plan Summary Plan Description (SPD) for the rules that apply.

A Social Security number is **REQUIRED** for every individual you wish to cover under the Insperity Group Health Plan. **ENROLLMENT WILL BE DELAYED** for any dependents for whom you do **not** provide a Social Security number on this form until their Social Security number(s) are provided. **If you do not provide missing dependent Social Security numbers within your designated enrollment period, then those dependents will NOT be covered, and you will have to wait until the next open enrollment period to enroll them. Exceptions:** Non-U.S. citizens that are not required to have a Social Security number (please identify below), and newborns under the age of one year. If you cannot provide a Social Security number for a newborn at this time, you should provide it to Insperity as soon as you obtain it in the future.

Common-law marriage may be formed in only a minority of states. State law marriage requirements generally determine whether a person may be enrolled as your common-law spouse.

*** Special Instructions for providing a PCP Physician ID No. below if you elect HMO coverage under one of these insurance carriers:**

- **Blue Shield of California:** *The Physician ID No. MUST be preceeded by the number 54220. Example: 54220-0000000.*
- **Kaiser Permanente (both California & Hawaii):** *Leave the **PCP Name** and **ID No.** fields blank below. Kaiser does not assign physician ID numbers, or require designation of a PCP on this enrollment request.*
- **Unity Health Plan (Dane Co., Wisconsin):** *Leave the Physician ID No. field blank.*

All other HMO carriers require that you provide AT LEAST a PCP ID No. in order to accurately designate a PCP of your own choosing.

EMPLOYEE INFORMATION

Please refer to the insurance carrier's Directory of Providers for in-network provider names & ID numbers.

Please enter your employee identification information in this section if this is your initial enrollment or if you have changes to submit.

☐ **Check here if you DO NOT have employee identification changes to submit.**
Any employee ID information you have previously submitted will continue to apply.

IF YOU ELECT HMO COVERAGE: *You are **required** to designate a* **PRIMARY CARE PHYSICIAN** *(PCP) for each dependent to be covered.**

IF YOU ELECT HMO COVERAGE: *Contact Insperity to see if your coverage option permits female members to select an* **OB/GYN PROVIDER** *in addition to a PCP.**

☐ Add ☐ Remove	**Employee Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /	E	Physician ID No. (Required) *	Physician ID No. (Required) *

DEPENDENT INFORMATION

Please refer to the insurance carrier's Directory of Providers for in-network provider names & ID numbers

☐ **I elect coverage for the eligible dependent(s) listed below.**
Please provide requested information below for ALL dependents to be covered.
If a dependent has no Social Security number yet, leave blank.

☐ I decline coverage for my eligible dependents.
☐ I do not have any eligible dependents to enroll at this time.

If you have submitted dependent information in the past and have NO dependent coverage changes (no additions or removals) at this time, check the box immediately below and leave the rest of the "Dependent Information" section blank.

☐ I do not have any **DEPENDENT** changes to submit at this time.

☐ I have attached a separate sheet to list additional dependents, using the format below.
A Relationship Code is required for each dependent: S = Spouse C = Child P = Domestic Partner
Please use the appropriate Relationship Code for any dependents you list below.
NOTE: *The **"S" (Spouse)** code should be used ONLY to indicate a person who is treated as an eligible employee's lawful spouse under federal law (including a common-law spouse).*

IF YOU ELECT HMO COVERAGE: *You are **required** to designate a* **PRIMARY CARE PHYSICIAN** *(PCP) for each dependent to be covered.**

IF YOU ELECT HMO COVERAGE: *Contact Insperity to see if your coverage option permits female members to select an* **OB/GYN PROVIDER** *in addition to a PCP.**

☐ Add ☐ Remove	**Dependent Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /		Physician ID No. (Required) *	Physician ID No. (Required) *
☐ Add ☐ Remove	**Dependent Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /		Physician ID No. (Required) *	Physician ID No. (Required) *
☐ Add ☐ Remove	**Dependent Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /		Physician ID No. (Required) *	Physician ID No. (Required) *
☐ Add ☐ Remove	**Dependent Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /		Physician ID No. (Required) *	Physician ID No. (Required) *
☐ Add ☐ Remove	**Dependent Name** (First, Middle Initial, Last)	Gender ☐ M	Date of Birth **REQUIRED**	Relation. Code	Primary Care Physician Name	OB/GYN Physician Name
	Social Security # REQUIRED _ _ _ – _ _ – _ _ _ _	☐ F	/ /		Physician ID No. (Required) *	Physician ID No. (Required) *

Please identify below by name ANY dependent to be covered who is:
– A non-U.S. citizen that is not required to have a Social Security number, **OR**
– 26 years of age or older (unless otherwise required by a state law that applies to your coverage) and is incapacitated and financially dependent.
NOTE: Verification of incapacitated status will require approval by your insurance carrier.

Dependent Name:	☐ Non-U.S. Citizen	☐ Incapacitated Adult
Dependent Name:	☐ Non-U.S. Citizen	☐ Incapacitated Adult
Dependent Name:	☐ Non-U.S. Citizen	☐ Incapacitated Adult

Terms of Participation

- By my signature (below) to these Terms of Participation, I request the enrollment/change which I have designated on this form. I agree to pay any required contributions, and authorize all applicable reductions from my compensation in payment of any required contributions. If I have elected high deductible health plan (HDHP) coverage, I also authorize the transmission of identifying data to Insperity's health savings account (HSA) vendor.
- I understand that any material misstatements, misrepresentations or omissions on this form (including with respect to my own or my dependents' eligibility) may result in coverage being void as of its effective date with no benefits payable. I also understand that the failure to notify Insperity of an enrolled dependent's loss of eligibility may result in the retroactive termination of coverage as of the date of such loss with no benefits payable.
- I understand that all coverage elected pursuant to this form (including coverage under the medical coverage option I have selected, if any) is subject to all terms of the group health plan(s) under which the coverage is being provided, including applicable insurance policies and similar arrangements.
- I understand that if I have selected **only** the Dental & Vision coverage option (if available as a separate election), I am waiving enrollment for medical coverage and may be similarly waiving certain Insperity-sponsored Welfare Plan benefits that are included in my benefits package and tied to my medical coverage, such as basic term life and personal accident insurance (PAI or AD&D). I also understand that, if I elect medical coverage and subsequently decide to drop such coverage, I may similarly lose any Insperity-sponsored Welfare Plan benefits that are included in my benefits package and tied to my medical coverage election.
- I understand that the reduction in my compensation authorized pursuant to these Terms of Participation will be in addition to any reductions under other agreements or benefits plans.
- I understand that I cannot change or revoke my enrollment election until the next open enrollment period, unless a mid-year election change event occurs that lets me cancel or change my election mid-year. If eligible, I elect to participate in the Insperity-sponsored cafeteria plan(s) applicable to my group health plan coverage, and authorize Insperity to reduce my compensation on a pretax basis by an amount equal to my required contribution for coverage. If not eligible for cafeteria plan participation, my compensation will be reduced on an after-tax basis by an amount equal to the required contribution for coverage.
- I understand that I will not be eligible to participate in the Insperity-sponsored cafeteria plan(s) applicable to my group health plan coverage if the Plan Administrator determines that I do not satisfy the eligibility rules of the cafeteria plan as of the date my election would have been effective, and in such case Insperity may withhold from my compensation any tax amounts owed for pretax contributions made while ineligible.
- I understand that the Plan Administrator (in its discretion and with or without my consent) may deem taxable any or all of my contributions at any time to the extent it deems appropriate for compliance with applicable law or the terms of the applicable cafeteria plan.
- I understand that the amount of my required contribution for coverage (and corresponding compensation reduction) is subject to change, and that the administrator for the applicable group health plan (and related cafeteria plan[s], if applicable) may change or cancel the amount of my compensation reduction in accordance with the terms of such plan(s), in its sole discretion and to the extent it deems appropriate for compliance with applicable law or the terms of such plan(s).
- I understand that my signature (below) to these Terms of Participation confirms that I have read and agree to these Terms of Participation, and that all information and statements provided on this form (including with respect to my own or my dependents' eligibility) are accurate and complete to the best of my knowledge and belief.

SIGN & DATE THE FORM	Employee Signature	Print Employee Name	Date Signed

State-Required Acknowledgments of Waived Health Benefits

Certain states or municipalities — currently Hawaii, Massachusetts, San Francisco and Vermont — have passed health care insurance ordinances that may require employees who waive employer-provided group health coverage to complete a specific waiver of coverage or other disclosure form.

Hawaii. Employees who live or work in Hawaii and who elect to waive employer-provided group health plan coverage must complete and return to Insperity the **Hawaii Form HC-5** no later than 30 days after their initial or annual open enrollment period ends, or they will be automatically enrolled in a designated coverage option. A blank copy of the Hawaii Form HC-5 is available online in Forms & Policies of the Employee Service Center at insperityservices.com, or by calling the Insperity Contact Center at 866-715-3552 (weekdays between 7 a.m. to 7 p.m. CT).

Massachusetts / San Francisco / Vermont. Employees who work in these states (or municipality) and who waive employer-provided group health coverage may be asked by their employer to complete a state- or municipality-required waiver of coverage or other disclosure form.

Kaiser Foundation Health Plan Arbitration Agreement

NOTE: If you elect coverage in the Kaiser Permanente HMO plan, you must read, sign and date this Arbitration Agreement.

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.

Employee/Subscriber Signature	Date Signed

Georgia Residents Only — Please Read and Sign Below

I hereby acknowledge that I have been informed of the following prior to my enrollment: (i) number, mix and location of participating / network health care providers; (ii) limitations of choices of participating / network health care providers; and (iii) disclosure of contractual relationship between participating / network provider and the insurer.

Employee Signature	Date Signed

Keep a copy of your completed enrollment form for your records.
Fax or mail pages 1-5 of the original of your completed Benefits Enrollment/Change Request to your Insperity payroll specialist.

Insperity

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION

If you meet eligibility requirements, and are actively at work on your coverage effective date, you may be covered under the Insperity Basic Life Insurance/ Accidental Death & Dismemberment (AD&D) policy. To designate a beneficiary or beneficiaries, or to change or update a previously submitted designation, review the Guidelines for Designation of Beneficiaries below, complete the information requested and sign and date this form.

Guidelines for Designation of Beneficiaries

- **Primary Beneficiaries.** Unless you designate a percentage, proceeds are paid to surviving primary beneficiaries in equal shares.
- **Contingent Beneficiaries.** Proceeds are paid to contingent beneficiaries only if there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, any proceeds paid to contingent beneficiaries will be paid to the surviving contingent beneficiaries in equal shares.
- If you do provide percentages, the total percentage in each category (primary or contingent) must equal 100%.
- Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).
- If no beneficiary is designated or there are no surviving primary or contingent beneficiaries, policy rules will govern payment of proceeds. However, if a previous designation has been made, you must provide a new designation of beneficiary in order to revoke the prior designation.
- Your beneficiary designation(s) will also apply in instances where an accident covered by the Insperity Basic AD&D policy results in death. (For covered accidents not resulting in death, the covered employee is the beneficiary of any proceeds paid by the AD&D policy.)
- The **Basic Life Insurance Beneficiary Designation form is not valid unless signed and dated.** If the form is not signed and dated, CIGNA will default to the last signed and dated form on file. If no previous form exists, CIGNA will determine the appropriate beneficiary through its standard policy rules.
- Use given names, not initials. Example: Mary R. Smith, not M.R. Smith or Mrs. John Smith.
- **Trust as Beneficiary.** You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]." If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.
- **Designation of Minors.** While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.
- **Life Status Changes.** You should review your beneficiary designation when significant life status events occur, such as marriage, divorce or birth of a child.
- **Community Property Laws.** If you are married and live in a community property state, and you name someone other than your spouse as beneficiary, the payment of benefits could be delayed or disputed unless your spouse also signs the beneficiary designation. **Community property states:** Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, Wisconsin.
- **See an attorney.** These guidelines are general, and are not intended to be relied upon as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous and meets legal requirements.
- You should review your beneficiary designation(s) annually, and submit revised designations or updated information as necessary.

Employee Last Name	Employee First Name	Middle Name or Initial	Employee Social Security Number

Basic Life and Basic Accidental Death & Dismemberment, Life Insurance Company of North America Policy Number FLX-051416

EMPLOYEE'S PRIMARY BENEFICIARY(IES)	ADDRESS	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO. OR TAX ID	PERCENTAGE (Total Must = 100%)
CONTINGENT BENEFICIARY(IES)	**ADDRESS**	**RELATIONSHIP TO EMPLOYEE**	**SOCIAL SECURITY NO. OR TAX ID**	**PERCENTAGE (Total Must = 100%)**

☐ **I have attached a separate sheet to list additional beneficiaries, using the format above.**

[If you need to attach a separate sheet, be sure it includes your printed full name and last 4 digits of your Social Security number. Sign and date the additional sheet.]

IMPORTANT! YOUR BENEFICIARY DESIGNATION IS NOT VALID WITHOUT A SIGNATURE & DATE ON THIS PAGE.		
SIGN & DATE THIS PAGE	Employee Signature (This signature attests ONLY to Basic Life Insurance Beneficiary Designation)	Date Signed
	Spouse Signature (May be required if you live in a community property state. See Guidelines above.)	Date Signed

Questions? Call Insperity toll-free at **866-715-3552** (weekdays from 7 a.m. to 7 p.m. Central time).

IMPORTANT INFORMATION

The Insperity Group Health Plan's (Plan's) Summary Plan Description (SPD), the benefit materials prepared by the insurer for your coverage option and your Insperity enrollment materials describe the benefits available under the Plan for enrollees in that coverage option and also explain some special rules for obtaining benefits. For each coverage option, the Plan pays only the benefits it has contracted with the insurer to provide. You are encouraged to contact your insurer if information in the Plan's SPD or the insurer's materials does not answer your questions. Once you are enrolled, further information is available online on Insperity's Employee Service Center, including access to your insurer's Web site.

Insurance Policies. Insperity provides life, disability, medical, vision and dental benefits through group insurance policies. Insperity does not self-fund these benefits.

Pre-Existing Conditions. Certain options under the Plan do not pay expenses for the treatment of a pre-existing condition during an individual's limitation period. A pre-existing condition generally means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within a specified look-back period (as defined under your coverage option) before your coverage eligibility date or, if applicable, before the first day of your waiting period. If a pre-existing condition limitation applies in your situation, no coverage is provided for expenses related to a pre-existing condition for a 12-month limitation period (or any shorter limitation period defined under your coverage option). (See the Coverage Options charts that are provided to all new employees in their Benefits Booklet to learn the look-back period and limitation that applies to your coverage option).

Your pre-existing condition limitation period may be eliminated or shortened one day for each day that you had prior creditable coverage under another health plan, provided there was not a lapse in coverage of 63 days or more. (A waiting period for plan eligibility is not counted as time associated with a lapse of coverage.) Most group health plans must provide a certificate of prior creditable coverage when a person's coverage terminates. If necessary, contact Insperity at the toll-free number below for help in obtaining a certificate of prior creditable coverage from a prior plan or other help in showing that you had creditable coverage.

The pre-existing condition limitation will not apply to:

(i) **genetic information** (unless a condition related to that information is diagnosed),

(ii) **pregnancy,**

(iii) **a condition of a newborn** (or adopted child) **who became covered within 30 days* of birth** (or adoption or placement for adoption), or

(iv) **children under the age of 19.**

* Or any longer period as required under state insurance law that applies to your coverage. The special enrollment period related to Medicaid and SCHIP is 60 days.

Enrollment and Special Enrollment. You and your eligible dependents may become enrolled in the Plan only during certain designated enrollment periods. As a newly eligible employee, you may first enroll for coverage (including coverage for your eligible dependents) during the 30-day* period following the date you become eligible. This 30-day period is called your initial enrollment period. In addition, as an eligible employee you may enroll for coverage during your annual open enrollment period. Insperity will tell you when your annual open enrollment period occurs. Outside of your initial enrollment period or open enrollment period, you may enroll for coverage only if a special enrollment event or other mid-year election change event (described below under "Changing Your Coverage") occurs.

A special enrollment event may occur if you decline Plan coverage for yourself or your eligible dependent(s) because of other health insurance coverage and that coverage is later lost (or the other plan sponsor stops contributing to, or otherwise terminates, that coverage). A special enrollment event may also occur if you or your eligible dependent(s) loses Medicaid or State Children's Health Insurance Program (SCHIP) coverage, or becomes eligible for a premium assistance subsidy for such coverage.*

In addition, a special enrollment event may occur if you obtain a new eligible dependent as a result of marriage, birth, adoption or placement for adoption. Refer to this Plan's SPD for more details about special enrollment events. If a special enrollment event occurs, you and your affected eligible dependents may become enrolled in the Plan if you request enrollment during the 30-day* period following the date of the special enrollment event.

Changing Your Coverage. Once enrolled, your Plan enrollment election will usually continue for the remainder of your coverage period unless you cancel or change your election. You can cancel or change your Plan enrollment election only during your open enrollment period or if you experience a mid-year election change event. The election change rules under this Plan and the Insperity Cafeteria Plan determine whether you have experienced a mid-year election change event (examples include marriage, divorce, death of a dependent, certain changes in employment status and certain cost and coverage change situations). If you experience a mid-year election change event, your election change must be consistent with that event and must be made within 30 days* of the event. The Plan Administrator for this Plan (and the Insperity Cafeteria Plan, if applicable) determines in its sole discretion whether your mid-year election change request is permitted. Refer to this Plan's SPD for a summary of the events that may enable you to change your Plan enrollment election mid-year and additional rules that apply.

Women's Health and Cancer Rights Act Benefits. As required by the Women's Health and Cancer Rights Act of 1998, Plan benefits are payable for covered expenses incurred by a person covered under the Plan for mastectomy-related services in a manner determined in consultation with the attending physician and patient for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema. These benefits are subject to the Plan's regular copayments and deductibles.

To Return Your Completed Enrollment Form

1. **MAKE A PHOTOCOPY** to keep for your records of all **six** pages of the form.
2. For fastest receipt and processing by Insperity, **FAX pages 1- 5** of your photocopy of the form to your Insperity payroll specialist.
3. If you prefer, you may **mail the original of your completed form** to your Insperity payroll specialist.
4. **FIND YOUR PAYROLL SPECIALIST'S address, fax and telephone numbers** in your enrollment materials, or online via the Employee Service Center (insperityservices.com).

Insperity must receive a completed enrollment form within 30 days of your eligibility to enroll (or any longer period as required under state insurance law that applies to your coverage)**. I**f you fail to submit your completed enrollment form to Insperity within 30 days of eligibility, you automatically waive your Insperity-sponsored Group Health Plan coverage and any associated welfare benefits.

Allow two weeks from the date Insperity receives your completed Benefits Enrollment form for your application to be processed by Insperity and your insurance carrier. It can then take up to four weeks for your insurance carrier to mail your membership ID card(s) to your home address. During this processing period, you may have to pay out-of-pocket for eligible expenses you incur, then file a claim for reimbursement. Claim forms are available online in Forms & Policies of the Employee Service Center at insperityservices.com.

Benefits Questions? Call Insperity toll-free (weekdays 7 a.m.–7 p.m. CT) at **866-715-3552**