



TO: _____

FROM: **Carol Kilgore, CPP**
Senior HR/PR Manager

DATE: _____

RE: **CHANGE OF ADDRESS**

Please find attached a number of documents which you may need to complete in order to ensure that Human Resources have current information with regard to your change of address.

1. Employee Information Sheet – Required to complete.
2. W-4 – Required to complete.
3. State Withholding – If applicable, you can find your state withholding form on Trends website/HR or contact me directly.
4. Direct Deposit Form – Complete only if you changed banking.
5. 401K Form – Required to complete.
6. Anthem Form – If enrolled required to complete.
7. Unum – Voluntary Benefits – If enrolled, required to complete.

If you should need additional information or if I can be of further assistance, please do not hesitate to contact me at 317-388-4007.

EMPLOYEE INFORMATION SHEET

NAME: _____

HIRE DATE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____

LOCAL/COUNTY: _____

STATE: _____

ZIP CODE: _____

HOME TELEPHONE: _____

CELL PHONE: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

ALTERNATE PERSON TO BE CONTACTED IN CASE OF EMERGENCY

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

HOSPITAL PREFERENCE: _____

FAMILY PHYSICIAN: _____ PHYSICIANS PHONE NUMBER: _____

ALLERGIES OR SIGNIFICANT FACTS THAT TREATING PARAMEDICS SHOULD
KNOW: _____

BLOOD TYPE (IF KNOWS): _____

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	
B	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► H	H	
For accuracy, complete all worksheets that apply.		{ • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.	

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074

2015

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	
6 Additional amount, if any, you want withheld from each paycheck	6	\$
7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature

(This form is not valid unless you sign it.) ►

Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
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Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over \$309,900 and you are married filing jointly or are a qualifying widow(er); \$284,050 if you are head of household; \$258,250 if you are single and not head of household or a qualifying widow(er); or \$154,950 if you are married filing separately. See Pub. 505 for details	1	\$ _____
2	Enter: { \$12,600 if married filing jointly or qualifying widow(er) \$9,250 if head of household \$6,300 if single or married filing separately }	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2015 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____
8	Divide the amount on line 7 by \$4,000 and enter the result here. Drop any fraction	8	\$ _____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	\$ _____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	\$ _____

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	\$ _____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	\$ _____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	\$ _____
Note.	If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.		
4	Enter the number from line 2 of this worksheet	4	\$ _____
5	Enter the number from line 1 of this worksheet	5	\$ _____
6	Subtract line 5 from line 4	6	\$ _____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$600	\$0 - \$38,000	\$600
6,001 - 13,000	1	8,001 - 17,000	1	75,001 - 135,000	1,000	38,001 - 83,000	1,000
13,001 - 24,000	2	17,001 - 26,000	2	135,001 - 205,000	1,120	83,001 - 180,000	1,120
24,001 - 26,000	3	26,001 - 34,000	3	205,001 - 360,000	1,320	180,001 - 395,000	1,320
26,001 - 34,000	4	34,001 - 44,000	4	360,001 - 405,000	1,400	395,001 and over	1,580
34,001 - 44,000	5	44,001 - 75,000	5	405,001 and over		1,580	
44,001 - 50,000	6	75,001 - 85,000	6				
50,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Federal Earned Income Tax Credit (EITC) Notification

Effective January 1, 2008, all employers are required to notify all of their employees of the federal Earned Income Tax Credit (EITC).

Assembly Bill 650, Stats. 2007, Ch. 606, (Lieu and Jones) requires any employer, who is subject to, and is required to provide unemployment insurance to employees, to notify all employees that they may be eligible for the EITC. Employers shall give notification within one week before or after, or at the same time, they provide employees with an annual wage summary (IRS Form W-2, 1099).

NOTICE TO EMPLOYEES

"Based on your annual earnings, you may be eligible to receive the earned income tax credit from the federal government. The earned income tax credit is a refundable federal income tax credit for low-income working individuals and families. The earned income tax credit has no effect on certain welfare benefits. In most cases, earned income tax credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families payments. Even if you do not owe federal taxes, you must file a tax return to receive the earned income tax credit. Be sure to fill out the earned income tax credit form in the federal income tax return booklet. For information regarding your eligibility to receive the earned income tax credit, including information on how to obtain the IRS Notice 797, or any other necessary forms and instructions, contact the Internal Revenue Service at 1-800-829-3676 or through its Web site at www.irs.gov."



Department of the Treasury Internal Revenue Service

Notice 797

(Rev. December 2014)

Possible Federal Tax Refund Due to the Earned Income Credit (EIC)

What Is the EIC?

The EIC is a refundable tax credit for certain workers.

Who May Claim the EIC?

You may be able to claim the EIC for 2014 if you worked and all four of the following conditions apply.

1. You (and your spouse, if filing a joint return) have a valid social security number (SSN) issued by the Social Security Administration. For more information on valid SSNs, see Pub. 596, Earned Income Credit (EIC).
2. Your 2014 earned income and adjusted gross income are both under \$38,511 (\$43,941 if married filing jointly) if you have one qualifying child; under \$43,756 (\$49,186 if married filing jointly) if you have two qualifying children; under \$46,997 (\$52,427 if married filing jointly) if you have three or more qualifying children; or under \$14,590 (\$20,020 if married filing jointly) if you do not have a qualifying child. For a definition of earned income, see the 2014 instructions for Form 1040, 1040A, or 1040EZ.
3. Your filing status on your 2014 tax return is any status except married filing a separate return.

4. You were not a qualifying child of another taxpayer in 2014.

If you **do not** have a qualifying child, you must also meet these conditions.

- a. You, or your spouse if filing a joint return, were at least age 25 but under age 65 at the end of 2014. (You meet this condition if you, or your spouse if filing a joint return, were born after December 31, 1949, and before January 2, 1990.) If your spouse died in 2014, see Pub. 596.
- b. You cannot be claimed as a dependent on someone else's 2014 tax return.

- c. Your home, and your spouse's if filing a joint return, was in the United States for over half of 2014. If you are in the military on extended active duty outside the United States, your home is considered to be in the United States during that duty period and you may be able to claim the EIC.

You **cannot** claim the EIC if any of the following conditions apply.

1. Your 2014 investment income (such as interest and dividends) is over \$3,350. See Pub. 596 for more information.
2. You file either Form 2555 or Form 2555-EZ (relating to foreign earned income).
3. You were a nonresident alien for any part of 2014 unless you were married to a U.S. citizen or resident and elected to be taxed as a resident alien for the entire year. See Pub. 519, U.S. Tax Guide for Aliens, for more information.

(Continued on back)

Who Is a Qualifying Child?

Any child who meets all four of the following conditions is a qualifying child.

1. The child is your son, daughter, stepchild, foster child, brother, sister, half brother, half sister, stepbrother, stepsister, or a descendant of any of them (for example, your grandchild, niece, or nephew). An adopted child is always treated as your own child. An adopted child includes a child lawfully placed with you for legal adoption. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
2. At the end of 2014, the child was under age 19 and younger than you (or your spouse, if filing jointly); or under age 24, a student, and younger than you (or your spouse, if filing jointly); or any age and permanently and totally disabled.
3. The child lived with you in the United States for over half of 2014. If the child did not live with you for the required time, there are exceptions if the child was born or died during the year, the child is presumed to have been kidnapped by someone who is not a family member, or there was a temporary absence.
4. The child does not file a joint income tax return for 2014.

There are additional rules if a child is married or is the qualifying child of more than one person. For details, see the 2014 instructions for Form 1040, 1040A, or 1040EZ.

How Do You Claim the EIC?

If you are eligible, claim the EIC on your 2014 income tax return. If you have a qualifying child, you must also fill in Schedule EIC and attach it to your Form 1040 or Form 1040A.

If eligible, you can claim the EIC to get a refund even if you have no tax withheld from your pay or owe no tax. For example, if you had no tax withheld in 2014 and owe no tax but are eligible for a credit of \$800, you must file a 2014 income tax return to get the \$800 refund.

More Information

This notice provides the basic requirements to qualify for the EIC. Refer to the instructions for Form 1040, 1040A, or 1040EZ; Pub. 596; or www.irs.gov/eitc for details. You can get IRS forms and publications at IRS.gov or by calling 1-800-829-3676.

**FOR STATE, COUNTY, CITY AND/OR TOWNSHIP
FORMS, PLEASE CONTACT LISA ALEXANDER
(EXT. 4042 OR
LALEXANDER@TRENDSINTERNATIONAL.COM)
OR CAROL KILGORE (EXT. 4007 OR
CKILGORE@TRENDSINTERNATIONAL.COM)**

Electronic Deposit Authorization Form

Important! Please read and sign before completing and submitting.

I hereby authorize Trends International, LLC hereinafter "Company" to initiate credit entries for sums to and payable to me to my checking, savings or other account(s) indicated below; and, the Financial Institution(s) named below, hereafter called "Depositories", to credit the same to such accounts. I also authorize Company to initiate debits for sums due to the Company for erroneous deposit or deposits at the Depository (ies).

This authorization is to remain in full force and effect until Company has received written notice from me of its termination in such time and in such manner as to afford Company reasonable opportunity to act on it or until such time as Company terminates this agreement.

Employee Name: _____ Social Security #: _____ - _____ - _____

Employee Signature: _____ Date: _____

REQUIRED – ATTACH A VOIDED CHECK FOR EACH CHECKING AND/OR SAVINGS ACCOUNT LISTED (NO DEPOSIT SLIPS WILL BE ACCEPTED).

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Be sure to indicate checking or savings, along with amount or percent to be deposited into each account.

1. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

2. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

3. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

Our payroll service charges Trends International, LLC \$15 for direct deposits that are rejected due to the inability to deposit your funds. Some of those reasons might be a cancelled account or your bank being bought out by another bank and their routing number changing. For these cases a new direct deposit form should have been submitted to the Payroll Department as soon as you knew of the change. Change forms are on the Trends website.

The \$15 will be charged back to you, if this occurs, on the next payroll date.

TRENDS INTERNATIONAL, LLC 401(K) PLAN

Change of Address
Enrollment Form

John J Doe
123-45-6789
Location: 9111320
Plan ID: 144955

NAME: _____
ADDRESS: _____

Contribution Selection

____ I wish to contribute _____ % of my compensation to the TRENDS INTERNATIONAL, LLC 401(K) PLAN (Enter a whole number between 1% - 90%)

Investment Election

Please indicate the percentage you would like to invest into the following funds. You must divide your investment in 1% multiples and your total must equal 100%. If you are unsure where to invest, examples of investment mixes are on page 6. Or, if you would like more information on these funds, please review the fund fact sheet and prospectuses provided by the Financial Advisor.

Fund Options	Percent of Contribution to Invest in Each Fund (Use whole numbers only.)	Fund Options	Percent of Contribution to Invest in Each Fund (Use whole numbers only.)
Invesco Stable Value Retirement Fd CL 5	_____ %	Oppenheimer Main St Small & Mid-Cap A	_____ %
BlackRock Global Allocation Fund A	_____ %	Blackrock Global Dynamic Equity A	_____ %
MFS Value Fund A	_____ %	Franklin Total Return Fund A	_____ %
Goldman Sachs Mid Cap Value Fund A	_____ %	Oppenheimer Global Strategic Income A	_____ %
BlackRock Mid-Cap Value Equity Port A	_____ %	PIMCO Real Return Fund A	_____ %
Prudential Jennison MidCap Gr A	_____ %	Victory Diversified Stock A	_____ %
Thornburg International Value R4	_____ %	Mainstay Large Cap Growth Fund Class R2	_____ %
GoalManager SM	_____ %	Select one only:	
<input type="checkbox"/> CONSERVATIVE PORTFOLIO MODEL <input type="checkbox"/> CONSERVATIVE TO MODERATE <input type="checkbox"/> MODERATE PORTFOLIO MODEL <input type="checkbox"/> MODERATE TO AGGRESSIVE <input type="checkbox"/> AGGRESSIVE PORTFOLIO MODEL			
Total 100%			

Remember your election percentages must total 100%

If you do not choose investments for your savings, your contributions will be invested in the **Invesco Stable Value Retirement Fd CL 5 (100%)**.

Authorization

____ Yes, I hereby authorize the payroll deduction. Signature: _____ Date: _____

____ No, I do not wish to contribute.* Signature: _____ Date: _____

Plan Administrator Signature: _____ Date: _____

* Even if you have chosen not to contribute at this time, you must still return this form to your Plan Administrator so they know that they offered you this benefit and you decided not to participate.

Please return this form to your Plan Administrator. You should also make a copy for your own records.

Enrollment Application
Group size 51+ eligible employees



INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings for HMO/POS plans can be obtained through www.anthem.com

TRENDS INTERNATIONAL

COMPLETE AREAS HIGHLIGHTED

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name TRENDS INTERNATIONAL		Employer address 5188 W. 74TH ST, INDIANAPOLIS, IN 46268		
Group no. 00084333	Sub-group no./ Life division no. 0000	Requested effective date 0 1 0 1 2 0 1 5	Life classification	Employee no./Dept. name

SECTION 2: REASON FOR APPLICATION - Required

<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA	<input type="checkbox"/> New hire	<input type="checkbox"/> Add dependent (Fill in Section 3)
<input checked="" type="checkbox"/> Annual open enrollment (N/A to Life)	Qualifying event _____ event date _____	<input type="checkbox"/> Rehire date _____	
<input type="checkbox"/> Waiver (To decline ALL coverage skip to Section 12)			

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date 0 1 0 1 2 0 1 5	<input type="checkbox"/> Marriage	<input type="checkbox"/> Adoption (Attach legal documentation)	<input type="checkbox"/> Loss of coverage (reason) _____	<input type="checkbox"/> Termed employment
	<input type="checkbox"/> Birth	<input type="checkbox"/> Legal guardianship (Attach legal documentation)	<input type="checkbox"/> Other _____	

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.	Type of coverage HSA Plan #1 Deductibles: <input type="checkbox"/> 2,000/4,000 HSA Plan #2 <input type="checkbox"/> 3,000/6,000	Employee only Employee+spouse (DP) Employee+child(ren) Family coverage No coverage
Dental To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.	Vision Type of coverage <input type="checkbox"/> PPO _____ <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> No coverage	Life <input checked="" type="checkbox"/> Life (Fill in Section 7)

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)
Sex <input type="checkbox"/> M <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> F <input type="checkbox"/> Divorced	Height	Weight	Home phone	Business phone	Email address
Address		City	State	ZIP code	County
Retired <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	Full-time hire date 40	Hours working per week Income reported by <input checked="" type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other
Complete Primary Care Physician (PCP) Information for HMO or POS plans only.				Anthem PCP ID no.	
Anthem PCP name and address				New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

*****ATTACH ADDITIONAL PAGES AS NEEDED TO LIST DEPENDENTS FOR**

SECTION 6.

Employee name _____

Social security no. _____

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner	Last name _____	First name _____	M.I. _____	Social security no. (required) _____			
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If spouse/DP address is different than employee, please provide full address _____							
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent	Last name _____	First name _____	M.I. _____	Social security no. _____	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)					If dependent address is different than employee, please provide full address _____		
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent	Last name _____	First name _____	M.I. _____	Social security no. _____	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)					If dependent address is different than employee, please provide full address _____		
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 7: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.

Current Income \$ _____	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Life Class	
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Optional Life _____ x Annual Earnings _____	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short-Term Disability _____
<input type="checkbox"/> Dependent Life	OR \$ _____	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long-Term Disability _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

Short-Term Disability _____ % Long-Term Disability _____ % Basic Life

Primary beneficiary

Last name _____	First name _____	M.I. _____	Social security no. _____	Relationship to employee _____	Age _____
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Contingent beneficiary

Last name _____	First name _____	M.I. _____	Social security no. _____	Relationship to employee _____	Age _____
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SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? Yes No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company _____	Policy/certificate no. _____	Effective date _____
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Policy/certificate holder name _____	Social security no. _____	Date of birth _____	Relationship to employee _____
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Are you and/or your dependents enrolled in Medicare or Medicaid? Yes No If yes, complete below.

Enrollee name _____	Medicare/Medicaid ID no. _____	Medicare Part A effective date _____	Medicare Part B effective date _____	ESRD onset date _____
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Enrollee name _____	Medicare/Medicaid ID no. _____	Medicare Part A effective date _____	Medicare Part B effective date _____	ESRD onset date _____
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Medicare Part D ID no. _____	Medicare Part D Carrier _____	Medicare Part D effective date _____	Medicare Part D term date _____
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Reason for Medicare entitlement: Age Disability ESRD & Disability End Stage Renal Disease (ESRD)

Employee name _____

Social security no. _____

SECTION 9: PRIOR HEALTH COVERAGE - RequiredHave you and/or your dependents had prior health coverage? Yes No If yes, complete below.

Have you been covered by Anthem within the past two (2) years <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy/certificate no.
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Group name/ID no.	Date policy in effect	Date policy termed
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Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

List prior carrier(s)	Date policy in effect	Date policy termed
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Please check the type of prior coverage

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee+Spouse/DP	<input type="checkbox"/> Employee+Child(ren)	<input type="checkbox"/> Employee+Spouse/DP+Child(ren)
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Termination reason:

<input type="checkbox"/> Divorce/legal separation	<input type="checkbox"/> Employment terminated	<input type="checkbox"/> Employer/group contribution ceased	<input type="checkbox"/> Other
<input type="checkbox"/> Death of spouse/DP	<input type="checkbox"/> COBRA coverage exhausted	<input type="checkbox"/> Group plan terminated	

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature _____

X

Date _____

COMPLETE THIS PAGE ONLY IF WAIVING COVERAGE

Employee name _____

Social security no. _____

SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
<input type="checkbox"/> Medical	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Dental	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Vision	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Life	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> All	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	

Check all that apply:

I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Please check if any of the following apply:

- I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- Other: _____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature _____

X

Date _____

****IF WAIVING COVERAGE, PLEASE LIST ALL FAMILY MEMBERS THAT YOU ARE WAIVING. IF FAMILY MEMBERS ARE NOT LISTED ABOVE, AND YOU HAVE A QUALIFYING EVENT OUTSIDE OF OPEN ENROLLMENT, THEY WILL NOT BE ELIGIBLE FOR INSURANCE.**



Underwritten by
Utum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Term Life and AD&D Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

GROUP PLAN #: 587672 DIVISION:

EMPLOYEE NAME (last name, first, middle initial)	EMPLOYER NAME TRENDS INTERNATIONAL	
EMPLOYEE ADDRESS (street, city, state, zip code)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

COVERAGE ELECTIONS

AMOUNT OF COVERAGE SELECTED FOR:

Life You: \$ _____ YOUR SPOUSE: \$ _____ EACH CHILD: \$ _____
AD&D \$ _____ \$ _____ \$ _____

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you DO NOT APPLY FOR coverage for you or your dependents(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Spouse Information (complete only if spouse coverage is selected)

NAME: **SOCIAL SECURITY #:** **DATE OF BIRTH:**

Beneficiary Information

NAME (last name, first, middle initial):	RELATION TO YOU:	BENEFIT %:
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

REQUEST FOR SIGNATURE Please read the back of this form carefully before signing below.

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature

Data

Work Phone

Home Phone