Axios, Inc. Employee Benefit Election Form
February 2014 through January 2015

Employee Name (please print)	Oscar, E. Ganteaume

Please check the appropriate boxes based on your benefit elections. The monthly amount you will pay to enroll in each plan is listed below:

Medical - PPO	Plan 1 QLM H9		Plan 2 QLP H9		Plan 3 MYQ H9 H.S.A.	
Employee	$382.08		$265.48		$137.63	
Employee/Child(ren)	$658.43		$514.23		$323.12	
Employee/Spouse	$803.90		$645.51		$421.02	
Employee/Family	$1,156.09		$963.35		$658.04	
Decline Coverage	Decline	✓	Decline	✓	Decline	✓

Dental / Vision	Dental		Vision	
Employee	**$28.30**		**$9.13**	
Employee/Child(ren)	**$72.71**		**$15.67**	
Employee/Spouse	**$60.50**	✓	**$15.37**	
Employee/Family	**$104.91**		**$24.80**	
Decline Coverage	**Decline**		**Decline**	

Voluntary Life	Coverage Level
Employee	
Spouse	
Child(ren)	
Decline Coverage	✓

Signature	Oscar Ganteaume	Date	01/27/2014

Your signature and date on the employee benefit election form authorizes Axios, Inc. to make the appropriate payroll deductions on a pre-tax basis as elected except for the Voluntary Life.

The Guardian Life Insurance Company of America
The Guardian Life Insurance company of America underwrites group term life, accidental death and dismemberment, short term disability, long term disability, critical illness, dental, vision, accident and cancer coverages.

Dominion Dental Services, Inc.
Dominion Dental Services, Inc. underwrites group pre-paid dental coverage.

Midwest Regional Office, P.O. Box 8012,
Appleton, WI 54912-8012

Enrollment/Change Form

Please print clearly and mark carefully.

Employer Name: **Axios, Inc.** | Group Plan Number: **00472733** | Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ☒ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class: All Eligible Employees | Division:_____ | Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name: Oscar, E. Ganteaume

Social Security Number: 590-47-1753

Address: 6518 Kerns Rd | City: Falls Church | State: VA | Zip: 22044

Gender: ☒ M ❑ F | Date of Birth (mm-dd-yy): 07-07-69 | Phone: (703) 532-1519

Email Address: OegBizz@Yahoo.com | Are you married or do you have a spouse? ☒ Yes ❑ No | Date of marriage/union: 05-16-2010

Do you have children or other dependents? ❑ Yes ☒ No | Placement date of adopted child: ____-____-____

About Your Job:

Hours worked per week: 40 | Job Title: Senior Software Engineer

Work Status: ☒ Active ❑ Retired ❑ Cobra/State Continuation | Date of full time hire: 05-12-11 | Annual Salary: $ 160.000

About Your Family: **Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.**

Spouse (First, MI, Last Name): Monika S. Mellem		Gender ❑ M ☒ F	Date of Birth (mm-dd-yyyy): 06-06-80	
Child/Dependent 1:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy): ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy): ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 3:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy): ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 4:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy): ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Vision ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Basic Life

❑ Voluntary Life ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Long Term Disability

❑ Short Term Disability

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse& Dependent/Child(ren)
PPO	❑ $28.30	☒ $60.50	❑ $72.71	❑ $104.91

❑ I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

- ❑ I am covered under another Dental plan
- ❑ My spouse is covered under another Dental plan
- ❑ My dependents are covered under another Dental plan

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature	❑ $9.13	❑ $15.37	❑ $15.67	❑ $24.80

☒ I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

- ❑ I am covered under another Vision plan
- ❑ My spouse is covered under another Vision plan
- ❑ My dependents are covered under another Vision plan

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

Policy Amount

Employee Only

☑ $50,000

NAME YOUR BENEFICIARIES (primary beneficiaries must total 100%)

Primary Beneficiary:

Name_____ %_____

Relationship to employee:_____

Name_____ %_____

Relationship to employee:_____

Contingent Beneficiary:_____

Relationship to employee:_____

(In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

Do you, the Applicant, have existing life insurance policies or annuity contracts? ❑ Yes ☒ No