First Name: Christopher | MI: M | Last Name: Carlson

Relationship to You: ☒ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SSN, write N/A): 418 30 7143

Gender: ☒ Male ☐ Female

Date of Birth (Month/Day/Year): 04 / 22 / 2018 | Age: 6

Product Selection(s): ☐ Medical ☒ Vision ☐ Dental

Dependent Status if Age 26 or Older: ☐ Disabled ☐ Act 4**

Full Name of Physician of Record (PCP) Group Practice: Dr. Wendy

PCP Number from Provider Directory:

Is Child an Established Patient? ☐ Yes ☐ No

First Name: TeaSadd | MI: K | Last Name: Hartgaszpromzon

Relationship to You? ☒ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SSN, write N/A): 857-03-4915

Gender: ☒ Male ☐ Female

Date of Birth (Month/Day/Year): 05 / 11 / 97 | Age: 26

Product Selection(s): ☐ Medical ☒ Vision ☐ Dental

Dependent Status if Age 26 or Older: ☐ Disabled ☐ Act 4**

Full Name of Physician of Record (PCP) Group Practice: Dr. Augusta Churchill

PCP Number from Provider Directory:

Is Child an Established Patient? ☒ Yes ☐ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

MEDICAL

N/A

I HEREBY DECLINE MEDICAL COVERAGE:

☐ For myself
☐ For family members ONLY
☒ For myself and ALL family members
☐ For the following family members:

REASON FOR DECLINING MEDICAL COVERAGE:

☐ Insured under spouse. Please provide spouse's employer and insurance carrier names:

☐ Other:

VISION

I HEREBY DECLINE VISION COVERAGE:

☐ For myself
☐ For family members ONLY
☐ For myself and ALL family members
☐ For the following family members:

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

☐ For myself
☐ For family members ONLY
☒ For myself and ALL family members
☐ For the following family members:

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and for my dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may ... the next ... group's renewal ... special enrollment, described below, occurs before coverage will be offered.

N/A

Employee/Contract Holder Signature | Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after you and your dependents' other coverage ends (or no later than 60 days if the other plan coverage was through Medicaid or a State Children's Health Insurance Program (CHIP)). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.