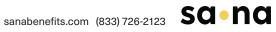


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Health Insurance Enrollment Form



Dependent: Spouse or Do	mestic Partner			
First Name	Last Name			
				Select the coverage your Spouse or Partner should be enrolled in.
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	Legal Sex	My spouse or	
		M F	partner lives	Medical
			at my address	Dental
Address (Street, City, State, ZIP) - Rec	quired if dependent does not live at your addres	38		
				Vision
Dependent: Child				
First Name	Last Name			
				Select the coverage this child
				should be enrolled in.
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	Legal Sex	This child lives	Medical
]-	M F	at my address	oaioai
Address (Street City State 71D) - Poo	quired if dependent does not live at your addres	20		Dental
Address (Street, Orty, State, 21F) - Nec	quired in dependent does not live at your address	15		Vision
Dependent: Child First Name	Last Name			
				Select the coverage this child
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	Legal Sex		should be enrolled in.
		M F	This child lives at my address	Medical
			at my address	Dental
Address (Street, City, State, ZIP) - Rec	quired if dependent does not live at your addres	SS		
				Vision
Dependent: Child				
First Name	Last Name			
				Select the coverage this child should be enrolled in.
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	Legal Sex		
		M F	This child lives at my address	Medical
				Dental
Address (Street, City, State, ZIP) - Rec	uired if dependent does not live at your addres	SS		Vision
				VISIOII

I certify that the information in this form is true and correct. I understand that any false information in this document may affect my eligibility and may disqualify myself and/or my dependents in any of the plans offered by Sana Benefits Inc. and/or its affiliates or affiliated providers. I also understand that, by declining coverage, I and/or my dependents voluntarily waive our rights to participate in employer-sponsored dental plans listed above.