

UBS Benefit Program 2002 Benefits Open Enrollment Election Form

Please complete all sections below and on the reverse side. Please be sure to sign and date the form in the section entitled "Your Authorization."

Personal	Information										
	Name:			Soc. Sec. No.:							
	Address:		_								
	City:			Date of Hire:/							
	State/Zip Code:										
Medical											
	Your monthly cost for medical cov percentage of your annual base sa Medical Plan option and coverage	lary, depending on the		The medical coverage options (the Choice Plan and all HMOs) are priced differently. For more information about the HMOs available in your location, see the Medical Plan Comparison.							
	Options			Coverage Category	Choice Plan Monthly Coverage Cost O		O Monthly				
	☐ No Coverage☐ Choice Plan			Employee Only	-	R 0.5%	-				
	☐ HMO* If you choose an HMO, enter I	HMO name:		Employee Plus One	,	R 0.9%	,				
	*You'll need to complete the HM0	oprollment form to aproll		Family	•	R 1.2%	,				
	Tou if need to complete the filling	o emoliment form to emoli.		Domestic Partner (see page 2 of the enrollment guide for details)							
 Dental											
	Option			Coverage Category	Monthly Coverage Cost						
	☐ No Coverage			Employee Only \$13.00							
	☐ Dental Plan			Employee Plus One \$21.75							
				☐ Family\$32.50							
Your Dep	endent Information										
	Complete the information below f cover under the Medical and/or Demedical column if the person is to Plan and/or an "X" in the dental covered under the Dental Plan.	ental Plans. Place an "X" in the be covered under the Medical	If you have additional dependents you'd like to cover, please write them on a separate page and submit along with this form. <i>Please note:</i> Domestic partners and children of domestic partners may qualify as dependents. See the enrollment guide for details.								
	Name (first, last)	Social Security Number	Sex	Relationship	Date of Birth Mo	edical	Dental				

10/2001 New Hire (over)

Reimburse	ement A	Accounts													
		one option tribute, writ				nd, if you elect									
	Health Care Reimbursement Account							Dependent Care Reimbursement Account							
	☐ I wish to participate. I elect to contribute \$ on an annual basis (minimum: \$240; maximum: \$5,000). ☐ I do not wish to participate.						I wish to participate. I elect to contribute \$ on an annual basis (minimum: \$240; maximum: \$2,000).								
							☐ I do not wish to participate.								
Long Term	n Disabi	lity													
					Maximu	m	Мо	onthly Cove	erage Cost						
					Monthly			er \$100 of Coverage							
	☐ Taxable \$25,000 \$0 ☐ Tax-Free \$25,000 \$0				\$3,000 No		No Cost								
						\$0.	\$0.20/\$100 of Eligible Pay								
					\$0.	0.48/\$100 of Eligible Pay (if your Eligible Pay is up to \$249,999)									
					\$0.	OR 0.68/\$100 of Eligible Pay (if your Eligible Pay is \$250,000 and over)									
Optional I	Life Insu	ırance													
	Coverage Option Please note: Evidence of insurability on the level of coverage you choose No Coverage 1 x Base Salary 4 x Base			e.			Tobacco-User Status Please indicate whether or not you are a user of tobacco products. For this purpose, a tobacco-user is defined as having smoked cigarettes or cigars, or used chewing tobacco between January 1, 2001 and December 31, 2001. If you do not respond, you'll default to tobacco-user status.								
	2 x Base Salary 5 x Base		5 x Base	· _			☐ Non-Tobacco-User ☐ Tobacco-User								
	Your I	Monthly Co	overage	Cost ner	\$1,000 c	of Coverage									
	10011	violitiny co	verage	cost per	\$ 1,000 C	Your Age (as	s of Janu	arv 1. 2002)						
Non-Tobaco Tobacco-Us		Under 30 \$0.04 \$0.06	30–34 \$0.06 \$0.08	35–39 \$0.07 \$0.11	40–4 \$0.1 \$0.1	45–49 0 \$0.18	50–54 \$0.26 \$0.45	55–59 \$0.44 \$0.74	60–64 \$0.74 \$1.17	65–69 \$1.34 \$1.86	70–74 \$2.11 \$3.08	75–80 \$3.23 \$4.71	81 and over \$5.19 \$7.75		
Dependen	t Lifo I	ncuranco													
Dependen		se Coverage	e Ontion	,	Monthly	Coverage Co	nc†	Child Co	verage Op	tion	Mont	thly Cover	rane Cost		
		Coverage	-		-	coverage co	,30		overage			iny cover	age cost		
		0,000							0						
		0,000						-	00						
		0,000						\$10,0			\$2.50				
		0,000													
Suppleme	ntal Ac	cidental De	eath and	Dismem	berment	t (AD&D) Insu	ırance								
	write in the amount of coverage you would like (from \$10,000 up to \$1,500,000, in \$10,000 increments). Please note: If you choose more than \$150,000 of coverage, the maximum coverage amount is 10 times your base salary. \$				000 up choose	Monthly Coverage Cost per \$1,000 of Coverage No Coverage \$0 Single \$0.018 Family \$0.032									
Group Leg	jal Plan														
	Optio	n			Monthly	Coverage Co	ost								
		o Coverage			\$0										
	□ Ва	ısic			\$15.79										
		omprehensiv	/e		\$24.44										
Your Auth	orizatio	on													
	I elect the benefit coverages indicated on this form. I understand I cannot change these elections before the next annual enrollment unless I have a family status change during the year, as defined by the IRS. By signing and submitting this form, I authorize any required					contributions to be made from my salary, based on the options and coverages I have selected. If I have selected no medical coverage, I certify that I have medical coverage elsewhere and will continue this alternate coverage throughout the plan year.									
	Your Signature						Date								