EMPLOYEE: COMPLETE SECTIONS 1-5. Please see rate sheet for all monthly costs.

SECTION 1: MEDICAL PLAN (Select one plan and one coverage level.)

- PERSONAL CHOICE PPO
- PERSONAL CHOICE PPO HIGH DEDUCTIBLE
- KEYSTONE POS
- KEYSTONE HMO

- SINGLE
- PARENT & CHILD(REN)
- EMPLOYEE & SPOUSE
- FAMILY

WAIVE (SEE SECTION 4) [ ]

SECTION 2: DENTAL (Single coverage is an employer-paid benefit. Select a coverage level only if enrolling dependents.)

- SINGLE [ ]
- PARENT & CHILD
- PARENT & CHILDREN
- EMPLOYEE & SPOUSE
- FAMILY

SECTION 3: SUPPLEMENTAL LIFE INSURANCE (Select “Waive” if receiving only the employer-paid basic benefit of $50,000.)

- EMPLOYEE
- SPOUSE
- CHILD(REN)

- COVERAGE AMOUNT

- Waive

NO CHANGES [ ]

SECTION 4: MEDICAL INSURANCE WAIVER

In order to waive medical coverage, certification of group medical insurance coverage in force elsewhere for the employee is required. Please complete the insurance information below. Please print.

Name of Insurance Company __________________________ Policy / Group # __________

Policyholder/Employer __________________________ ID # __________

SECTION 5: SUMMARY

I wish to become insured for the coverage chosen as evidenced by my signature below and agree to the following:

1. I authorize the above selections and, any pre-tax and/or after-tax reductions in pay, as specified on the rate sheet.
2. I understand that insurance applications are requested for each plan in which I enroll and must be submitted by the due date to ensure enrollment.
3. I understand that if I waive medical coverage, the subsidy that I receive is fully taxable.
4. I understand that I cannot change or revoke these elections unless that change or revocation is on account of and consistent with a life event change in status.

SIGNATURE __________________________ DATE __________

Life Event Change Date

Marriage [ ] Divorce [ ] Birth/Adoption [ ] Loss of other group coverage [ ] Enrollment in other group coverage [ ] Other [ ]

EMPLOYEE: PLEASE KEEP A COPY FOR YOUR RECORDS