

ENROLLMENT FORM - Print clearly in ink.

Name of Employee _____
 Last First Initial Social Security # Birth Date Home Phone

Mailing Address _____
 City State Zip Business Phone Date of Hire Hours Worked Weekly

Employer _____ Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Name of Spouse: _____
 Last First Initial Birth Date Social Security #

<u>Names of Dependent Children</u>	<u>Sex</u>	<u>Birth Date</u>	<u>Social Security #</u>

Type of Coverage: Employee Only Employee & Spouse Employee & Child Employee & Children Family
 Medical: _____ Dental: * Yes No Vision: * Yes No Disability: * Yes No

Group Life Insurance: * Smoker Non-Smoker Amount: \$10,000 \$25,000 \$50,000 \$75,000 \$100,000 Other _____
 Spouse: Smoker Non-Smoker Amount: \$10,000 \$25,000 \$50,000 \$75,000 \$100,000 Other _____

* Dental, Vision, Disability and Life insurance are subject to employer election and approval. Life insurance amounts in excess of \$25,000 require pre-approval.

Dependent Life: None One \$3,000 Unit Two \$3,000 Units (\$6,000 total)

Beneficiary: _____
 Name Relationship Contingent

Spouse's: _____
 Beneficiary: Name Relationship Contingent

EMPLOYEE SIGNATURE

DATE

<u>For Office Use Only</u>	
Effective Date: _____	Termination Date: _____
Class Change Date: _____	VGL Amount: _____
Disability Income Amount: _____	
<input type="checkbox"/> Original Group	<input type="checkbox"/> Special Enrollee
<input type="checkbox"/> New Employee	<input type="checkbox"/> Late Enrollee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information during the application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

WMI EE APP (11/07)

WAIVER OF GROUP COVERAGE

(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY ANY ELIGIBLE EMPLOYEE)

EMPLOYEE NAME _____ SOCIAL SECURITY # _____ EMPLOYER NAME _____

REASON FOR DECLINING COVERAGE (CHECK ONE):

- | | |
|--|--|
| <input type="checkbox"/> I WAIVE ALL COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY) | <input type="checkbox"/> COVERED BY SPOUSE'S COVERAGE |
| <input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY) | <input type="checkbox"/> COVERED BY OTHER INSURANCE OR HMO |
| <input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY | <input type="checkbox"/> COVERED BY CHAMPUS OR CHAMPVA |
| <input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY | <input type="checkbox"/> OTHER (EXPLAIN) _____ |

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department at (801) 263-8000 or (800) 748-5340.

EMPLOYEE SIGNATURE

DATE