Once you've enrolled, you'll also receive access to Healthy Rewards, a discount health and wellness program.
You can save up to 60% on fitness center memberships, weight management programs, health-related magazines, and much more!

CIGNA®

Level 2 – Cost Per Paycheck

Myself only	$18.89
Myself and 1 dependent	$46.28
Family	$69.89

Level 1 – Cost Per Paycheck

Myself only	$9.84
Myself and 1 dependent	$24.11
Family	$36.41

STEP 3: Enroll Now.

Choose Your Enrollment Method *(select one)*

Your Group Number: 2582

A) Enroll by Phone: Call 1-877-552-5015 to enroll. Benefit Specialists are available Monday–Friday, 5:00am to 6:00pm MST.

B) Enroll Online: Visit www.starbridgeselect.com to enroll quickly and securely from the convenience of your personal computer.

C) Enrollment Form: Simply complete this enrollment form and turn it in to your manager.

First Name Allan J. Initial J.

Last Name Gabrial

Date of Birth 10/14/86 Gender (M) F

Soc. Sec # 494-19-9926 Hire Date _____ Unit # _____

Address 1301 N. Cleveland Ave #9

City Sioux Falls State SD Zip 57103

Which Plan or Plans?

Check your desired plans. Prices reflect cost per paycheck. Once enrolled, changing to another plan level may only be done annually.

___ I want the **Level 2 Plan**
✓ I want the **Level 1 Plan**
___ I want the **Dental Plan**

Who Do You Want to Cover?

Check only one, even if multiple plans are chosen.

___ I want to cover myself only
___ I want to cover myself and 1 dependent
___ I want to cover my family

Dependents

If additional spaces are needed, please attach separate sheet.

Full Name	Gender	Relationship	Date of Birth

Beneficiary

Person who will receive benefits in the event of your death.

Loda P. Lore Counsel

Print Full Name Relationship to You

X Allan J. Gabrial 6/18/10

Sign Here To Enroll Date

Authorization: I hereby elect to participate in the Starbridge Select Insurance Plan for benefits made available under Internal Revenue Code Section 79, 105, 106, 125 and these Sections as amended. I understand that the Plan will automatically convert to pre-tax status any eligible payroll deductions which are provided through the Plan. I understand that by participating in this Plan my Social Security benefits may be reduced since these premiums will be deducted before my salary is taxed. This election will remain in effect for the Plan Year. My election CANNOT be changed during the Plan Year in accordance with Internal Revenue Service Guidelines unless a qualifying event occurs which includes: marriage, divorce, legal separation, death of spouse, birth or legal adoption of child, death of child, spousal change of employment affecting insurance coverage, eligibility to Medicare or Medicaid or change in residence affecting insurance coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

Declination Notice: No, I do not wish to enroll in the coverage offered above.WAIVER OF COVERAGE: Failure to elect coverage (for yourself and/or any of your dependents) during the Open Enrollment Period may result in no coverage until the next Open Enrollment Period. It may not be necessary to wait for the next Open Enrollment Period if you qualify as a Special Enrollee. Please fill out top, sign, and date.

X _____ _____

Signature if Declining Coverage Date

Once you've enrolled, you'll also receive access to Healthy Rewards, a discount health and wellness program.
You can save up to 60% on fitness center memberships, weight management programs, health-related magazines, and much more!

CIGNA®

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Myself and 1 dependent	$46.28
Family	$69.89

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Myself only	$9.84
Myself and 1 dependent	$24.11
Family	$36.41

STEP 3: Enroll Now.

Choose Your Enrollment Method *(select one)*

Your Group Number: 2582

A) Enroll by Phone: Call 1-877-552-5015 to enroll. Benefit Specialists are available Monday–Friday, 5:00am to 6:00pm MST.

B) Enroll Online: Visit www.starbridgeselect.com to enroll quickly and securely from the convenience of your personal computer.

C) Enrollment Form: Simply complete this enrollment form and turn it in to your manager.

First Name Marnas Initial P
Last Name Kow
Date of Birth 11.19.76 Gender (M) / F
Soc. Sec # 503-37-1472 Hire Date ____ Unit # ____
Address 3105 N. Cypress place
City Sioux Falls State SD Zip 57104

Which Plan or Plans?

Check your desired plans. Prices reflect cost per paycheck. Once enrolled, changing to another plan level may only be done annually.

___ I want the **Level 2 Plan**
X I want the **Level 1 Plan**
X I want the **Dental Plan**

Who Do You Want to Cover?

Check only one, even if multiple plans are chosen.

X I want to cover myself only
___ I want to cover myself and 1 dependent
___ I want to cover my family

Dependents

If additional spaces are needed, please attach separate sheet.

Full Name	Gender	Relationship	Date of Birth

Beneficiary

Person who will receive benefits in the event of your death.

Mary Paul Kow — Sister
Print Full Name — Relationship to You

X Marnas Kow — 06.19.08
Sign Here To Enroll — Date

Authorization: I hereby elect to participate in the Starbridge Select Insurance Plan for benefits made available under Internal Revenue Code Section 79, 105, 106, 125 and these Sections as amended. I understand that the Plan will automatically convert to pre-tax status any eligible payroll deductions which are provided through the Plan. I understand that by participating in this Plan my Social Security benefits may be reduced since these premiums will be deducted before my salary is taxed. This election will remain in effect for the Plan Year. My election CANNOT be changed during the Plan Year in accordance with Internal Revenue Service Guidelines unless a qualifying event occurs which includes: marriage, divorce, legal separation, death of spouse, birth or legal adoption of child, death of child, spousal change of employment affecting insurance coverage, eligibility to Medicare or Medicaid or change in residence affecting insurance coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

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X ____
Signature if Declining Coverage — Date