

EMPLOYEE INFORMATION (Must Be Filled Out) ENROLLMENT FORM - PLAN 2 PRINT USING BLACK OR BLUE INK ESC/ES/P2D/144

Social Security Number 593-14-0992
 Date of Birth 01/24/1982 Sex M F
 Name Benjamin Rollison
 Street Address 15610 S Dorado Ave
 City Centennial State CO Zip 80015
 Home Phone 303-810-2961

Do you or any dependents have Medicare?
 Yes No If Yes:
 Medicare Health Insurance Claim Number (HICN) _____
 Medicare Effective Date ____/____/____
 Names of Covered Person(s)
 1. _____
 2. _____
 3. _____

BENEFIT SELECTION Weekly Rates

MEDICAL 
 \$23.69 Employee Only
 \$48.08 Employee + One
 \$64.20 Employee + Family
 NO to all benefits.
 If NO is checked, sign and date the bottom of the form.
 This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL 
 YES \$ 5.23 Employee Only
 YES \$10.46 Employee + One
 NO \$17.26 Employee + Family

VISION 
 YES \$2.35 Employee Only
 YES \$4.00 Employee + One
 NO \$5.64 Employee + Family

TERM LIFE 
 YES \$0.60 Employee Only
 YES \$0.90 Employee + One
 NO \$1.80 Employee + Family

SHORT-TERM DISABILITY 
 YES \$4.20 Employee Only
 NO
 Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

You MUST enroll in the Medical Insurance Plan before adding any additional benefits. Your coverage level for the additional benefits will be identical to your medical plan selection.

REQUIRED DEPENDENT INFORMATION

Name Owen Rollison *see attached form for additional dependents*
 Social Security Number 653-40-0014
 Date of Birth 06/24/2006 Sex M F
 Relationship: Spouse Child Domestic Partner

Name Jaw Rollison
 Social Security Number 653-50-8087
 Date of Birth 10/10/2008 Sex M F
 Relationship: Spouse Child Domestic Partner

Name Paige Rollison
 Social Security Number 677-37-2246
 Date of Birth 09/16/2011 Sex M F
 Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life \ Accidental Loss of Life, Limb & Sigit, please write in your beneficiary information.
 NAME OF BENEFICIARY Michelle Rollison
 RELATIONSHIP wife DOB: 9/16/1981
 Accidental Loss of Life, Limb & Sigit is part of the Medical Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.
 Signature [Signature] Date 11/02/2015

Here is my enrollment form
I have 4 dependents

Owen 653-40-0014

Ian 653-50-8087

Paige 677-37-2246

Michelle 047-72-6218. Wife

6* DOB: 9/16/1981

*Additional
Dependent **