

CALEY P. JARMAN

FEMALE

11-29-07 DOB

DAUGHTER

TIFFANY M. JARMAN

FEMALE

4-24-80 DOB

WIFE

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 Justin Initial M
 Last Name Jarman
 Date of Birth 7/12/81 Gender M F
 Soc. Sec # 504962673 Hire Date 11/11/07 Unit # _____
 Address 607 S. Plucker Place
 City Sioux Falls State SD Zip 57106

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.

<u>Caleb M. Foster Jarman</u>	<u>M</u>	<u>Son</u>	<u>7/21/99</u>
Full Name	Gender	Relationship	Date of Birth
<u>Calen L. Jarman</u>	<u>M</u>	<u>Son</u>	<u>8/5/02</u>
Full Name	Gender	Relationship	Date of Birth

Beneficiary

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

Tiffany Jarman Wife
 Print Full Name Relationship to You

Justin Jarman 12/19/07
 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.

 Signature if Declining Coverage Date