

FIBERS MEDICAL ENROLLMENT ELECTION

COMPLETE ONLY IF YOU ARE A PRE-65 ENROLLEE

TO BE COMPLETED BY PARTICIPANT						
EFFECTIVE DATE	PAY GROUP	PARTICIPANT STATUS	ELECTION			
1/1/10	Salaried	<input type="checkbox"/> RETIREE (UNDER AGE 65) <input type="checkbox"/> SURVIVING SPOUSE (UNDER AGE 65)	AETNA OPEN ACCESS MANAGED CHOICE (AOMC) (PPO)			
LAST NAME	FIRST NAME	MI	BADGE NUMBER	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH
STREET ADDRESS			CITY	STATE	ZIP CODE	
TELEPHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS				
MEDICAL COVERAGE ELECTION						
<input type="checkbox"/> ELECT COVERAGE <input type="checkbox"/> WAIVE COVERAGE		<input type="checkbox"/> PARTICIPANT ONLY (01) <input type="checkbox"/> PARTICIPANT + SPOUSE (02) <input type="checkbox"/> PARTICIPANT + DEPENDENT CHILDREN (03) <input type="checkbox"/> PARTICIPANT + FAMILY (04)				

Please provide requested information below for each dependent you elect to cover who meets the eligibility requirements of the Sterling Medical Plan.

DEPENDENT CODE:	1 SPOUSE	2 NATURAL/ADOPTED CHILD	3 STEPCILD IN HOME	4 LEGAL GUARDIANSHIP		
DEPENDENT'S SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	SEX	DEPENDENT CODE	BIRTH DATE MM/DD/YY

I elect the coverage indicated above. Coverage cannot be changed until the following calendar year unless I have a "Qualified Change in Family Status" (marriage, divorce, birth, adoption, death of spouse or child, or termination of employment of spouse). I also understand that if any covered dependent no longer meets the eligibility requirement, this individual will no longer be entitled to benefits and I must submit a new enrollment form to the Human Resources Department discontinuing coverage for that individual. If I am an active employee, I authorize withholding on a pre-tax basis of applicable deductions from my pay check.

_____ DATE

PARTICIPANT SIGNATURE

TO BE COMPLETED BY HUMAN RESOURCES

[] Aetna _____ [] Ceridian _____