

TO BE COMPLETED BY PARTICIPANT

| EFFECTIVE DATE | PAY GROUP | PARTICIPANT STATUS | ELECTION |
|----------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| 1/1/10 | <input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY | <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIREE (UNDER AGE 65) <input type="checkbox"/> DISABLED <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> COBRA | <input type="checkbox"/> AETNA OPEN ACCESS HMO (AOHMO) <input type="checkbox"/> AETNA OPEN ACCESS MANAGED CHOICE (AOMC) (PPO) |

| LAST NAME | FIRST NAME | MI | BADGE NUMBER | SOCIAL SECURITY NUMBER | SEX | DATE OF BIRTH |
|-----------|------------|----|--------------|------------------------|-----|---------------|

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| STREET ADDRESS _____ _____ CITY STATE ZIP CODE _____ TELEPHONE NUMBER _____ CELL PHONE NUMBER _____ E-MAIL ADDRESS _____ | IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, IS SPOUSE ELIGIBLE FOR MEDICAL COVERAGE THROUGH HIS/HER OWN EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPOUSE IS NOT ELIGIBLE FOR MEDICAL COVERAGE UNDER STERLING MEDICAL PLAN. IF NO, PLEASE PROVIDE INFORMATION ON SPOUSE'S EMPLOYER FOR VERIFICATION. Employer Name: _____ Employer Address: _____ _____ Employer Phone Number: _____ Employer Contact Name: _____ |
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MEDICAL COVERAGE ELECTION

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

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|-----------------|----------|-------------------------|---------------------|----------------------|
| DEPENDENT CODE: | 1 SPOUSE | 2 NATURAL/ADOPTED CHILD | 3 STEPCHILD IN HOME | 4 LEGAL GUARDIANSHIP |
|-----------------|----------|-------------------------|---------------------|----------------------|

| DEPENDENT'S SOCIAL SECURITY NUMBER | LAST NAME | FIRST NAME | MI | SEX | DEPENDENT CODE | BIRTH DATE MM/DD/YY |
|------------------------------------|-----------|------------|----|-----|----------------|---------------------|
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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.

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| _____ PARTICIPANT SIGNATURE | _____ DATE |
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TO BE COMPLETED BY HUMAN RESOURCES

[] Aetna _____ [] Ceridian _____