Human Resources Use Only

COV Code	MEM Cov	EFF Date

2004 Group Insurance Enrollment/Change Form

Employee Information

Employee Name (Last, First, M.I.) *Please print*	Employee No.	Social Security No.	Marital Status ❑ Married ❑ Single

Home Address	City	State	Zip

Dept. Name	Location/Station	Hire Date	Full Time Date	Sex ❑ Female ❑ Male	Date of Birth

I am regularly scheduled to work. *Check one.*

❑ **Full-time (40+ hours per week)** ❑ **Part-time (15-39 hours per week)**

Enrollment/Change Type *Check one*

❑ **New Employee** ❑ **Rehired Employee** ❑ **Open Enrollment (Annual)** ❑ **Family/Work Status Change**

Reason for status change. **Effective Date:**_____

❑ **Marriage** ❑ **Divorce** ❑ **Legal separation** ❑ **Change in beneficiary (see reverse side)** ❑ **Other**_____

❑ **Birth** ❑ **Adoption** ❑ **Death** ❑ **Ineligible dependent** ❑ **Part-time to Full-time**

Health Care (Premiums are deducted from paychecks on a pretax basis.)

Employee Medical Insurance *Check one*

❑ **Enhanced PPO Option**
Enhanced Dental (Ortho)
Vision Benefits

❑ **Basic PPO Option**
Traditional Dental (NO Ortho)
Vision Benefits

❑ **Decline**
(medical, dental, vision)

Dependent Medical Insurance *(list all dependents to be covered including those currently enrolled)*

For dependents who are 21 years of age or older, indicate whether or not they are currently enrolled as full-time students.

Family dental coverage is available to full-time employees only.

Dependent	Enroll	Cancel	Name (Last, First, M.I)	Social Security No.	Gender M/F	Student Y/N	Date of Birth
Spouse	❑	❑					
Child	❑	❑					
Child	❑	❑					
Child	❑	❑					
Child	❑	❑					

Total number of dependents to be covered: _____

Disability

Short-term Disability Insurance

If you are an eligible employee, you are automatically enrolled for this coverage at a nominal cost, unless you decline coverage by checking the box below. Premiums are deducted from paychecks on a pretax basis.

❑ **I elect coverage.** ❑ **I decline coverage.**

Long-term Disability Insurance

After one year of continuous eligible employment, full-time employees not covered by a collective bargaining agreement are automatically enrolled in this plan at no cost to them. Pilots are eligible after two years of full-time service.

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Life/AD&D Insurance/Business Travel Accident

Full-time eligible employees are automatically enrolled at no cost to them.

Beneficiary Designation — Primary

Relationship	Name (Last, First, M.I) and Address	Social Security No.	Date of Birth	Distribution (% of Total Benefit) *Must Equal 100%*

Beneficiary Designation — Secondary

Voluntary Accident Insurance

Refer to Employee Benefits booklet for schedule of accident insurance and rates. Premiums are deducted from paychecks on a pre-tax basis. ***Check one.***

❑ **Individual Plan** ❑ **Family Plan** ❑ **I decline coverage**

Coverage amount: $_____ ($300,000 maximum in multiples of $25,000. Not more than 10 times your annual salary.)

Effective date: _____

Beneficiary Designation — Primary

Relationship	Name (Last, First, M.I)/Address	Social Security No.	Date of Birth	Distribution (% of Total Benefit) *Must Equal 100%*

Beneficiary Designation — Secondary

Voluntary Group Universal Life Insurance

To enroll in this plan, complete the Group Universal Life Insurance enrollment form. Premiums are deducted from paychecks on an after-tax basis.

Signature

Please enroll me for coverage as indicated above. I understand this authorizes ABX Air, Inc. to deduct my share of the cost of medical, short-term disability and voluntary accident insurance if any, on a pretax basis. I understand I cannot change my election before the next open enrollment period unless I have a qualifying change in family/work status (for example marriage, legal separation, divorce, birth, adoption, or a change in my scheduled hours worked per week; a change in my spouse's employment status). See your Employee Benefits booklet for details on family/work status.

Employee Signature_____ **Date**_____

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