Human Resources Use Only

COV Code	MEM Cov	EFF Date

2004 Group Insurance Enrollment/Change Form for Flight Crewmembers

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

Enrollment/Change Type

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*

❑ Traditional Medical Plan
Traditional Dental
Vision Benefits

❑ Enhanced PPO
Enhanced Dental
Vision Benefits

❑ Exclusive Provider Organization
Traditional Dental
Vision Benefits
(Limited to existing enrollees)

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.

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 two years of continuous eligible employment, Flight Crewmembers are automatically enrolled in this plan at no cost to them.

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Life/AD&D Insurance

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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