COV Code	MEM Cov	EFF Date

2010 Retiree Open Enrollment Form

Participant Information

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

Home Address	City	State	Zip

Sex ❑ Female ❑ Male	Date of Birth				

Enrollment Type

Open Enrollment effective date March 1, 2010

Health Care

Health Insurance check one:

❑ UHC Enhanced PPO	❑ UHC Value PPO	❑ UHC Traditional Plan	❑ Decline (you may not re-enroll at a later date)

Dependent Medical Insurance

For dependents who are 21 years of age or older for the Traditional Plan or 19 or older for the Enhanced or Value Plans, indicate whether or not they are currently enrolled as full-time students. Premiums are deducted from paychecks on a pretax basis.

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

Total number of dependents to be covered: _____

Signature

Please enroll me for coverage as indicated above. I understand that there are no dental, vision or other benefits associated with the retiree medical plans. I understand that payments are due on the first day of the month and I authorize the premium to be deducted from my pension check unless I indicated otherwise. I understand that failure to make payment in a timely manner will result in my coverage being terminated with no opportunity for reinstatement. 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, or adoption; or a change in my spouse's employment status). See your Employee Benefits booklet for details on family/work status.

Participant Signature **Date**

Please return to: ABX Air, Inc., Benefits 2061B
145 Hunter Drive
Wilmington, OH 45177