



Human Resources Use Only

COV Code	MEM Cov	EFF Date
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2002 Group Insurance Enrollment/Change Form

Employee Information					
Employee Name (Last, First, M.I.) <i>Please print</i>		Employee No.	Social Security No.	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
Home Address		City	State	Zip	
Dept. Name	Location/Station	Hire Date	Full Time Date	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth
I am regularly scheduled to work. <i>Check one.</i> <input type="checkbox"/> Full-time (40+ hours per week) <input type="checkbox"/> Part-time (15-39 hours per week)					
Enrollment/Change Type <i>Check one</i>					
<input type="checkbox"/> New Employee		<input type="checkbox"/> Rehired Employee		<input type="checkbox"/> Open Enrollment (Annual)	
<input type="checkbox"/> Family/Work Status Change				Effective Date: _____	
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce		<input type="checkbox"/> Legal separation	
<input type="checkbox"/> Birth		<input type="checkbox"/> Adoption		<input type="checkbox"/> Death	
<input type="checkbox"/> Change in beneficiary (see reverse side)		<input type="checkbox"/> Other _____		<input type="checkbox"/> Ineligible dependent	
<input type="checkbox"/> Part-time to Full-time					
Health Care (Premiums are deducted from paychecks on a pretax basis.)					
Employee Medical Insurance <i>Check one</i>					
<input type="checkbox"/> Enhanced PPO Option Enhanced Dental (Ortho) Vision Benefits		<input type="checkbox"/> Basic PPO Option Traditional Dental (<u>NO</u> Ortho) Vision Benefits		<input type="checkbox"/> Decline (medical, dental, vision)	
Dependent Medical Insurance <i>(list all dependents to be covered including those currently enrolled)</i>					
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
Spouse	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
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.					
<input type="checkbox"/> I elect coverage.		<input type="checkbox"/> 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.					

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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) <i>Must Equal 100%</i>

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) <i>Must Equal 100%</i>

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 Airborne Express 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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