



2010 ENROLLMENT / CHANGE / TERMINATION FORM

A. Employee Information

Last Name		First Name	MI	Social Security Number	
Street Address		City	State	Zip	
Home Phone	Work Phone		Region	Site Location	
Date of Hire	Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	

B. Type of Request (Check one box only)

<input type="checkbox"/> Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Coverage Status Change	<input type="checkbox"/> Termination
<input type="checkbox"/> New Employee <input type="checkbox"/> Rehired or Reinstatement of Coverage <input type="checkbox"/> Late-Enrollment/Special Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA Effective Date _____ Rehire Date _____	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Drop Dependent <input type="checkbox"/> Add New Coverage <input type="checkbox"/> Canceling <input type="checkbox"/> Other _____ Effective Date _____	Reason for change: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of other coverage	<input type="checkbox"/> Cancel Dependent Coverage <input type="checkbox"/> Terminating Employment <input type="checkbox"/> Death Effective Date _____

C. Election Summary

UnitedHealthcare

PRE-TAX and AFTER-TAX: A pre-tax deduction lowers your taxable income and increases your take-home pay. Insurance premiums may also be deducted on an after-tax basis. An after-tax election allows you to cancel your benefits mid-year; you do not have to wait until the next open enrollment. If you are enrolling for the first time and fail to make a pre-tax/after-tax election on this form, your benefits will be **pre-tax**. If you are currently enrolled you will stay with the same tax election unless you change it here. **Your tax election must be made on this form for each benefit you select.**

Costs listed below are per paycheck.

Pre-Tax	After-Tax	Plan Options	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive / Waive Reason*
<input type="checkbox"/>	<input type="checkbox"/>	UHC Gold (Buy-up) Plan	<input type="checkbox"/> \$89.61	<input type="checkbox"/> \$265.89	<input type="checkbox"/> \$250.01	<input type="checkbox"/> \$440.55	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/>	UHC Silver (HRA) Plan	<input type="checkbox"/> \$23.08	<input type="checkbox"/> \$124.74	<input type="checkbox"/> \$115.57	<input type="checkbox"/> \$225.47	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/>	Vision Plan	<input type="checkbox"/> \$1.34	<input type="checkbox"/> \$3.28	<input type="checkbox"/> \$3.50	<input type="checkbox"/> \$5.48	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/>	UHC Dental Low Option	<input type="checkbox"/> \$5.34	N/A	N/A	<input type="checkbox"/> \$19.29	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/>	UHC Dental High Option	<input type="checkbox"/> \$11.54	N/A	N/A	<input type="checkbox"/> \$34.25	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance <small>(see section D for rates)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

*Waive Reason: 1 – Other Insurance 2 – Spouse Coverage 3 – Can't Afford 4 – AHCCCS 5 – Other / explain

AFLAC (Supplemental / Voluntary)

You must sign-up directly with an AFLAC representative for these benefits

(rates are provided in your AFLAC packet)

- | | |
|---|---|
| <input type="checkbox"/> Personal Accident Indemnity Plan | <input type="checkbox"/> Personal Disability Income Protector (Short Term Disability) |
| <input type="checkbox"/> Hospital Protection Plan | <input type="checkbox"/> Limited Benefit Cancer Indemnity Insurance |

401(k) Retirement Plan

Reminder – You no longer have to wait for open enrollment to participate in the 401(k). You are eligible as long as you are 19 years old and have completed 90 days of employment. You may enroll online at www.accountservices.aul.com (you will need our plan # G31472) or contact Jon Stetzel to enroll manually.

- I wish to have Jon Stetzel contact me. I waive 401(k) participation.

For information regarding the 401(k) Plan:

Please contact Jon Stetzel, Compensation/Retirement Manager at CPES Corporate Office (520) 884-7954



Last Name, First Name M.

Location:

D. Supplemental Life and Accidental Death & Dismemberment (AD&D) (UnitedHealthcare)

You can calculate your cost by finding your age in the chart below. Your age is the current year minus your year of birth.
****FINAL COST MAY VARY DUE TO ROUNDING****

Employee Cost Per Month For Life/AD&D Coverage Per \$10,000

Age	Rate / \$10,000 Employee Smoker	Rate / \$10,000 Employee Non-Smoker	Rate / \$10,000 Spouse
< 30	\$1.28	\$0.75	\$0.54
30 – 34	\$1.62	\$0.86	\$0.65
35 – 39	\$2.45	\$1.30	\$1.01
40 – 44	\$4.10	\$1.80	\$1.72
45 – 49	\$7.04	\$3.11	\$2.86
50 – 54	\$12.56	\$5.59	\$4.58
55 – 59	\$16.68	\$9.64	\$6.36
60 – 64	\$21.68	\$13.83	\$9.04
65 – 69	\$42.98	\$22.95	\$13.50
70 – 74	\$58.81	\$35.46	\$22.49
75+	\$127.42	\$94.82	\$54.92
Child	\$1.20		
AD&D	N/A		

Employee Supplemental Life Insurance: \$10,000 increments from \$10,000 to \$500,000. New hire guarantee issue of \$100,000 not to exceed 5x base annual earnings.

I elect \$ _____ of Employee Supplemental Life Insurance.

Tobacco Use
 Non-Tobacco Use

Waive Coverage

Supplemental Spouse Life Insurance: \$5,000 increments from \$5,000 to \$250,000 not to exceed 50% of the employee's supplemental election. Guarantee issue of \$50,000.

I elect \$ _____ of Supplemental Spouse Life Insurance.

Waive Coverage

Supplemental Child Life Insurance: \$2,000 increments from \$2,000 to \$10,000. Guarantee issue of \$10,000.

I elect \$ _____ of Supplemental Child Life Insurance

Waive Coverage

Guarantee issue coverage is only available during new employee's initial enrollment. All elections in excess of the guarantee issue will require satisfactory evidence of insurability (excluding existing amounts currently enrolled). Late entrants must provide satisfactory evidence of insurability before any supplemental elections go into effect. See the Benefit Manager for the forms. One time open enrollment.

LIFE CALCULATION:

$$\frac{\text{Amount Elected}}{\text{Rate From Table Above}} \times \text{Rate From Table Above} \div \$10,000 \times 12 = \frac{\text{Annual Cost}}{\text{Pay Periods}} \div \frac{26}{\text{Pay Periods}} = \$ \frac{\text{Pay Period Deductions}}{\text{Pay Periods}}$$

E. Beneficiary Information: Designate your beneficiary(ies) below.

NOTE: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

PRIMARY BENEFICIARY(ies)

Name (last name, first, middle initial)	Percentage	Relationship to Insured	Address

CONTINGENT BENEFICIARY(ies)

Name (last name, first, middle initial)	Percentage	Relationship to Insured	Address

COMPLETE THE REMAINING SECTIONS OF THIS FORM TO PROVIDE ADDITIONAL REQUIRED INFORMATION FOR YOUR ELECTIONS



Last Name, First Name M. Location:

F. Dependent Information

List all dependents to be covered. Student status information is required for all dependents who exceed the age of 19. Indicate coverage choice for each dependent.

Last Name	First Name	MI	Relationship	Sex	Date of Birth	Social Security Number	Coverage	Change	F/T Student*
				M F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> Yes <input type="checkbox"/> No
				M F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> Yes <input type="checkbox"/> No
				M F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> Yes <input type="checkbox"/> No
				M F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> Yes <input type="checkbox"/> No
				M F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> Yes <input type="checkbox"/> No

*** It is your responsibility to provide verification to the insurance carrier of student status each semester your dependent child is enrolled.**

G. Other Health Information (This section must be completed.)

On the day coverage begins will any family member including those not listed above be covered by another health or dental insurance or Medicare?
 YES NO **If yes, fill out this section. Use an additional sheet if more than one additional policy will be in force.**

Coverage Type <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medicare	Insurance Company Name and (Area Code) Phone Number	
Policy Coverage Dates _____ to _____	Name of Insured	Family Members Covered
Insured's Employer	Policy Number	

H. Employee Signature

Community Provider of Enrichment Services, Inc. offers employee benefits that are covered under Section 125 of the Internal Revenue Service Code, which allows pre-tax deductions for certain insurance premiums. Under IRS regulations, the pre-tax elections you make for January 1 through December 31, 2009 are binding and cannot change unless you experience a certain "life event". As defined by the IRS, these include a Family Status Change, a Special Event, or a Cost or Coverage Change in any of either your or your spouse's plans. You have 31 days to notify the Benefit Manager to determine how that change might affect your eligibility status and to complete any necessary paperwork. Failure to notify the Benefit Manager within this time frame will eliminate your ability to make changes until the following open enrollment period.

ACKNOWLEDGEMENT:
 I have read the above paragraph and understand the terms, rates, and restrictions regarding the benefits offered.

Employee Signature _____
Date Signed

Print Employee Name