

STEP 1 - EMPLOYMENT & PAY STATUS

CHECK ONE: ACTIVE NO PAY COBRA LTD

CHECK ONE: MONTHLY PAID WEEKLY PAID

STEP 2 - PERSONAL INFORMATION

FERMI ID LAST NAME FIRST NAME MIDDLE INITIAL

STEP 3 - COMPLETE FOR CHANGE OF ADDRESS AND/OR PHONE NUMBER ONLY

HOME PHONE #:

ADDRESS CITY STATE ZIP CODE

STEP 4 - MEDICAL PLAN CHANGE / SELECTION AND LEVEL OF COVERAGE

CHECK APPROPRIATE BOXES No Change (go to Step 6) Change Medical Plan Change Family to Single Add/Waive Medical Coverage Change Single to Family

** I waive coverage. I and/or my dependents have medical coverage under another plan. I understand by waiving coverage I can subsequently only enroll during an open enrollment period or when I qualify under special enrollment requirements under HIPAA of 1999.

OFFICE USE ONLY Effective Date

Employee 10/01/06

Family 10/01/06

CHECK ONE CIGNA Open Access Plus CINGA Network POS * HMO Illinois * Blue Advantage HMO * Waive Coverage ** CHECK ONE EMPLOYEE (single) ONLY FAMILY

OFFICE USE ONLY OAP - Benf Class/Sec Code: FACT POS - Benf Class/Sec Code: FACT Cigna Ben.Code: 100IL053 HMOIL - Benf Class/Sec Code: 0000 BLAD - Benf Class/Sec Code: 0000 Coverage Change Effective Date: 10/01/06

IMPORTANT - If you are choosing an HMO product (Cigna Network POS, Blue Advantage, or HMO Illinois) you MUST select a Primary Care Physician (PCP) and provide the PCP name and ID# where indicated below. Please refer to the appropriate Directory for listings. Under these plans you are required to obtain, in advance of treatment, all authorizations and referrals from you PCP.

STEP 5 - LIST YOURSELF AND ELIGIBLE DEPENDENTS YOU WANT COVERED OR DROPPED FROM YOUR MEDICAL PLAN AND MARK THE APPROPRIATE BOXES

Table with columns: Name, Medical Coverage (ADD/DROP), Social Security Number, Sex, Date of Birth, Care Physician Name, POS 10 digit MD ID#

STEP 6 - DENTAL PLAN CHANGE / SELECTION AND LEVEL OF COVERAGE

CHECK APPROPRIATE BOXES No Change (go to Step 8) Change Dental Plan Change Family to Single Add/Waive Dental Coverage Change Single to Family

** I waive coverage. I and/or my dependents have medical coverage under another plan. I understand by waiving coverage I can subsequently only enroll during an open enrollment period or when I qualify under special enrollment requirements under HIPAA of 1999.

OFFICE USE ONLY Effective Date

Employee 10/01/06

Family 10/01/06

CHECK ONE CIGNA DENTAL PPO CIGNA DENTAL CARE (HMO) * WAIVE COVERAGE ** CHECK ONE EMPLOYEE (single) ONLY FAMILY

OFFICE USE ONLY PPO - Benf Class/Sec Code: FACT HMO - Benf Class/Sec Code: FACT Coverage Change Effective Date: 10/01/06

IMPORTANT - If you are choosing Cigna Dental Care (HMO) you MUST select a dental office within the Cigna Dental Care Network of providers and provide the dental office number where indicated below. Additionally, under this plan you are required to obtain dental services from that provider unless authorized and referred elsewhere. Please refer to the Cigna directory for a listing.

STEP 7 - LIST YOURSELF AND ELIGIBLE DEPENDENTS YOU WANT COVERED OR DROPPED FROM YOUR DENTAL PLAN AND MARK THE APPROPRIATE BOXES

Table with columns: Name, Dental Coverage (ADD/DROP), Social Security Number, Sex, Date of Birth, CIGNA DENTAL CARE (HMO) ENTER 6 DIGIT DENTAL OFFICE # BELOW

EMPLOYEE NOTIFICATION - Single employees are eligible to select only one health plan. Married employees are eligible to select only one health plan for themselves and dependents. (If husband and wife are both employees of URA/Fermilab, they cannot be covered under more than one health plan. Each can be in a separate plan, but each cannot be covered under two plans. Their eligible children are covered as dependents of only one parent.)

EMPLOYEE AUTHORIZATION AND CERTIFICATION - I authorize URA/Fermilab to deduct from my paycheck the appropriate contributions, if any, to the employee benefit plans that I have elected. Contributions for medical and dental coverage will be deducted on a before tax basis unless the employee signs a waiver form. I hereby certify that the information that I have provided on this form is true and correct to the best of my knowledge.

STEP 8

EMPLOYEE SIGNATURE: DATE: BENEFITS OFFICE: DATE: