

STEP 1 - EMPLOYMENT & PAY STATUS

CHECK ONE: ACTIVE COBRA LTD

CHECK ONE: MONTHLY PAID WEEKLY PAID

STEP 2 - PERSONAL INFORMATION

EMPLOYEE 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 COVERAGE AND LEVEL OF COVERAGE

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

CHECK ONE CIGNA Open Access Plus WAIVE COVERAGE \*\* CHECK ONE EMPLOYEE (single) ONLY 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 OAP - Benf Class/Sec Code: DCACT Coverage Change Effective Date: 10/01/06

OFFICE USE ONLY Effective Date Employee 10/01/06 Family 10/01/06

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, This section intentionally left blank. Rows for SELF, SP, CH.

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

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

CHECK ONE CIGNA DENTAL PPO CIGNA DENTAL CARE (HMO) \* WAIVE COVERAGE \*\* CHECK ONE EMPLOYEE (single) ONLY 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 PPO - Benf Class/Sec Code: DCACT HMO - Benf Class/Sec Code: DCACT Coverage Change Effective Date: 10/01/06

OFFICE USE ONLY Effective Date Employee 10/01/06 Family 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. Rows for SELF, SP, CH.

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/Fermlab, 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/Fermlab 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: OFFICE: DATE: