

**FERMI NATIONAL ACCELERATOR LABORATORY**

**\*\* COMPLETE ONLY IF MAKING CHANGES \*\***

**GROUP EMPLOYEE BENEFITS  
OPEN ENROLLMENT FORM**

**\*\* COMPLETE ONLY IF MAKING CHANGES \*\***

CHECK ONE: <input type="checkbox"/> ACTIVE <input type="checkbox"/> NO PAY <input type="checkbox"/> COBRA <input type="checkbox"/> LTD MEDICAL CHANGE: FROM: _____ MED. TO: _____ ↓ INDICATE CHANGE, IF ANY ↓	CHECK ONE: <input type="checkbox"/> MONTHLY PAID <input type="checkbox"/> WEEKLY PAID DENTAL CHANGE: FROM: _____ DENT. TO: _____ ↓ INDICATE CHANGE, IF ANY ↓
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ID \_\_\_\_\_ LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ FERMILAB PHONE# \_\_\_\_\_

MEDICAL COVERAGE	LEVEL OF COVERAGE	OFFICE USE ONLY Effective Date
<p><b>CHECK ONE</b></p> <input type="checkbox"/> CIGNA Open Access Plus (Formerly PPO) <input type="checkbox"/> CIGNA Network POS <input type="checkbox"/> HMO ILLINOIS <input type="checkbox"/> BLUE ADVANTAGE HMO <input type="checkbox"/> WAIVE COVERAGE	<div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <p align="center"><b>OFFICE USE ONLY</b></p>                 Benf Class/Sec Code: _____                  Benf Class/Sec Code: _____ Cigna Ben.Code: _____                  Benf Class/Sec Code: _____                  Benf Class/Sec Code: _____                  Coverage Change Effective Date: <b>10/01/05</b> </div> <p><b>CHECK ONE</b></p> <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> FAMILY	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Employee</div> <div style="border: 1px solid black; padding: 5px;">Family</div>

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

**LIST YOURSELF AND ELIGIBLE DEPENDENTS YOU WANT COVERED UNDER YOUR MEDICAL PLAN, OR WRITE "CANCEL" NEXT TO THOSE YOU WISH TO DROP**

Name: Last / First / M.I.	Social Security Number (if available)	Sex	DOB	BLUE ADVANTAGE, HMO IL & POS Primary Care MD Name	BLUE ADVANTAGE, HMO IL 2-4 digit ID# or POS MD#
SELF:					
SP:					
C1:					
C2:					
C3:					

DENTAL COVERAGE	LEVEL OF COVERAGE	OFFICE USE ONLY Effective Date
<p><b>CHECK ONE</b></p> <input type="checkbox"/> CIGNA DENTAL PPO <input type="checkbox"/> CIGNA DENTAL HEALTH (HMO) <input type="checkbox"/> WAIVE COVERAGE	<div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <p align="center"><b>OFFICE USE ONLY</b></p>                 Benf Class/Sec Code: _____                  Benf Class/Sec Code: _____                  Coverage Change Effective Date: <b>10/01/05</b> </div> <p><b>CHECK ONE</b></p> <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> FAMILY	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Employee</div> <div style="border: 1px solid black; padding: 5px;">Family</div>

If you are waiving dental coverage for yourself or your dependents (including your spouse), you may only subsequently enroll during an open enrollment period.

**LIST YOURSELF AND ELIGIBLE DEPENDENTS YOU WANT COVERED UNDER YOUR DENTAL PLAN, OR WRITE "CANCEL" NEXT TO THOSE YOU WISH TO DROP**

Name: Last / First / M.I.	Social Security Number (if available)	Sex	DOB	CIGNA DENTAL HEALTH (HMO) ENTER 6 DIGIT DENTAL OFFICE # BELOW
SELF:				
SP:				
C1:				
C2:				
C3:				

**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.

EMPLOYEE SIGNATURE	DATE	BENEFITS OFFICE	DATE
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FB/BEN.Acf-9/01/2005