



KELLY & ASSOCIATES INSURANCE GROUP, INC.

301 International Circle · Hunt Valley, Maryland 21030-1342 · (410) 527-3432 · Fax: (410) 527-3905 · www.kaig.com

EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

Please fill in the boxes completely:

New Subscriber

Member adding line of coverage

WAIVER (Signature Required)

COBRA

Retiree

Company Name:

KELLY
Company ID#:

Business Phone#:

() _____

| | | | | | | |
|-------------------|------------------------|--------------------------------------|---|--|--|------------------------------|
| EMPLOYEE | 1 Last Name _____ | | First Name _____ | | MI _____ | Title (Jr., Sr., etc.) _____ |
| | Street Number _____ | Street Name _____ | | | Apt# _____ | |
| | City _____ | | State _____ | Zip Code _____ | E-mail _____ | |
| | Social Security# _____ | Date of Birth (MM-DD-YY) _____ | Gender M <input type="checkbox"/> F <input type="checkbox"/> | Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Partner* <input type="checkbox"/> | On your effective date, will you be actively at work on a full-time basis for this employer? <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Home Phone# _____ | | Full-time Hire Date (MM-DD-YY) _____ | Requested Effective Date (MM-DD-YY) _____ | | KELLY USE ONLY: <input type="checkbox"/> D | |

* Domestic partner coverage availability is based on carrier and employer authorization.

| 2 DEPENDENTS | Name (Last, First, MI) | Relationship | Social Security # | Birth Date | Gender | FIT Student (Y/N)** | Disabled (Y/N) | Dependent Elections | POS or HMO plans only: | | Existing Patient (Y/N) |
|--------------|------------------------|--------------|-------------------|------------|--------|---------------------|----------------|---|-------------------------------|-------------------------------|------------------------|
| | | | | | | | | | Line 1: PCP Physician Name | Line 2: OB/GYN Physician # | |
| | | Subscriber | | | | | | Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> | | | |
| | | | | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | | | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | | | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | | | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |

** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)

Participating Dentist Name/Code/Office#: _____ Existing Patient: Y N

If Eligible for Medicare: Effective Date (Part A): / / Effective Date (Part B): / / Effective Date (Part D): / /

| 3 PLANS | HEALTH | DENTAL | VISION | Plan Name | Benefit Amount | Smoker? |
|--|---|--|---|------------------------------------|----------------|----------------------------|
| | Grp#: _____ | Grp#: _____ | Grp#: _____ | <input type="checkbox"/> Life AD&D | _____ | \$ _____ |
| Carrier: _____ | Carrier: _____ | Carrier: _____ | <input type="checkbox"/> Vol. Life | _____ | \$ _____ | <input type="checkbox"/> Y |
| Plan: _____ | Plan: _____ | Plan: _____ | <input type="checkbox"/> Vol. AD&D | _____ | \$ _____ | <input type="checkbox"/> Y |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Individual | <input type="checkbox"/> Individual | <input type="checkbox"/> Vol. Sp. Life | _____ | \$ _____ | <input type="checkbox"/> Y |
| <input type="checkbox"/> Individual & Child(ren) | <input type="checkbox"/> Individual & Child(ren) | <input type="checkbox"/> Individual & Child(ren) | <input type="checkbox"/> Vol. Dep. Life | _____ | \$ _____ | <input type="checkbox"/> Y |
| <input type="checkbox"/> Individual & Adult | <input type="checkbox"/> Individual & Adult | <input type="checkbox"/> Individual & Adult | <input type="checkbox"/> STD | _____ | \$ _____ | _____ /wk |
| <input type="checkbox"/> Family | <input type="checkbox"/> Family | <input type="checkbox"/> Family | <input type="checkbox"/> Vol. STD | _____ | \$ _____ | _____ /wk |
| <input type="checkbox"/> Over 65 & Working FT | <input type="checkbox"/> Waive Coverage | <input type="checkbox"/> Waive Coverage | <input type="checkbox"/> LTD | _____ | \$ _____ | _____ /mo |
| <input type="checkbox"/> Over 65 & Retired | CDH Funding Arrangement: <input type="checkbox"/> HSA <input type="checkbox"/> HRA <input type="checkbox"/> FSA | | <input type="checkbox"/> Vol. LTD | _____ | \$ _____ | _____ |
| <input type="checkbox"/> Waive Coverage | HSA/HRA/FSA Calendar Year Election Amount \$ _____ | | <input type="checkbox"/> Suppl. Life/AD&D | _____ | \$ _____ | _____ |

4 Employee Occupation _____ Employee Class _____ Employee Salary _____

Primary Beneficiary _____ Relationship _____

Secondary Beneficiary _____ Relationship _____

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? Yes No

Other Health Insurer Name _____

Who is covered? Self Spouse/Partner All Policy# _____

Effective Date / / Term Date / /

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief, full, complete and true as of this date. I further certify that I am the spouse/partner, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.

THIS IS NOT AN APPLICATION FOR INSURANCE

6 EMPLOYEE SIGNATURE _____ DATE / /

EMPLOYER SIGNATURE / VERIFICATION _____ DATE / /