

Fond du Lac Insurance Company

Benefit Enrollment Form

Section A

Division	100- Programs	G00-	FDLTH	700- BBC	☐ 800- BBH	☐ 900- BBG	
1	New Enrollment Effective:				Change Effective:		
	Add Dependant Effective:					ffective:	_
	Other Changes Effective:_						
Section B	}						
EMPLOYE	EE INFORMATION						
Name:						On all 1 On accellate Name to an	Male
	Last	First		M.I.		Social Security Number	Female
Date of Bir		Status	. Single Marri	e Divorced	Domestic Partne	Telephone Number:	
Address							
	Street				City	State Zip Code	
EMPLOYI	EE TRIBAL ENROLI	LMENT I	NFORM	ATION			
Are you:	Enrolled in a Federally R Child or Grandchild of a				al Affiliated gnized Tribe		
Enrollee	Name:						
	Last			Firs	,	Full Middle	
Name of	Federally Recogn	nized Tr	ibe:	7 110	Enrollment N		
	, ,						
Section C	1						
COVERAC	GE .						
Medical	Employee Only	Family	Decline	Othor			
Dental	H	H					
Basic Life	<u> </u>	<u> </u>		Other			
MEDICAL	PLAN SELECTION	ſ					
	eductible Plan- I und					cost to me for Single nthly medical premium will be	
						wo payments per month and	
	etax basis.					no paymonio por moniir and	
Deductible	s and Out of Pocket	Maximum	n under th	ne High Dedu	ctible Plan will b	e:	
	Single Cove	rage	Family	y Coverage			
	\$4,000 Deduc	tible	\$7,00	00 Deductible			
	\$5,500 Out of Poc	ket Max.	\$10,000 O	ut of Pocket Max			
for Single (premium w	Coverage; if I choose	to elect F nderstand	Family Co	overage unde	r the Low Deduc	130.00 per month premium stible Plan the total monthly med into two payments per	lical
Deductible	s and Out of Pocket	Maximum	n under th	ne Low Dedu	ctible Plan will be) :	
	Single Cove	rage	Family	y Coverage			
	\$2,000 Deduc			00 Deductible	4		
	\$3,400 Out of Poc	ket Max	\$5,800 Ou	t of Pocket Max	J		
	remiums are for Fam lease contact the Ber					ere is a additional monthly prem	nium of

^{***}If you are electing Single Coverage please skip to Section E***

Section D

SI OCSE/ DOI	MESTIC PARTNER INFO	RMATION					
Name:							
				Social Security Number			
Address:	Last First	M.I.			Male		
Address.					Female		
	Street	City	State	Zip	T emaic		
Birth Date:							
SPOUSE/ DON	MESTIC PARTNER TRIBA	AL ENROLLMENT IN	FORMATION				
Is your spouse/ domestic partner: Enrolled in a Federally Recognized Tribe Non-Tribal Affiliated							
Enrollee Na	ame:						
		.		5 ""			
Name of Fe	Last ederally Recognized Tr	rihe:	Enrollment N	Full Middle			
ivallie of Le	derally Necognized 11	ibe.	Linominenti	iumber.			
DEPENDANT	INFORMATION						
Name:							
	Leaf Eleaf			Social Security Number			
Address:	Last First	M.I.			Male Female		
	Street	City	State	Zip			
Birth Date:		Reside with you?	No	Full Time Student? Yes	No		
		Do you claim on Taxes?	Yes No	**If student please provide sch	nool name below.		
Relationship:	Relationship: Child Step Child Name of School						
DEPENDANT	TRIBAL ENROLLMENT	INFORMATION					
Is your Dependant: Enrolled in a Federally Recognized Tribe Non-Tribal Affiliated Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe							
Enrollee Na	Child or Grandchild of						
Enrollee Na	Child or Grandchild of ame:	f an Enrolled Member of a Fe	derally Recognized	Tribe Full Middle			
Enrollee Na	Child or Grandchild of	f an Enrolled Member of a Fe		Tribe Full Middle			
Enrollee Na	Child or Grandchild of ame:	f an Enrolled Member of a Fe	derally Recognized	Tribe Full Middle			
Enrollee Na	Child or Grandchild of Arme: Last ederally Recognized Tr	f an Enrolled Member of a Fe	derally Recognized	Tribe Full Middle			
Enrollee Na Name of Fe DEPENDANT Name:	Child or Grandchild of Ame: Last ederally Recognized To Sinformation	f an Enrolled Member of a Fe First ribe:	derally Recognized	Tribe Full Middle			
Enrollee Na Name of Fe DEPENDANT Name:	Child or Grandchild of Arme: Last ederally Recognized Tr	f an Enrolled Member of a Fe	derally Recognized	Full Middle			
Enrollee Na Name of Fe DEPENDANT Name: Address:	Child or Grandchild of Arme: Last ederally Recognized To State St	f an Enrolled Member of a Fe	Enrollment N	Full Middle lumber: Social Security Number	☐ Male		
Enrollee Na Name of Fe DEPENDANT Name: Address:	Child or Grandchild of Ame: Last ederally Recognized To Sinformation	f an Enrolled Member of a Fe First ribe: M.I. City	Enrollment N	Full Middle lumber: Social Security Number	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address:	Child or Grandchild of Arme: Last ederally Recognized To State St	f an Enrolled Member of a Fe	Enrollment N	Full Middle lumber: Social Security Number	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address:	Child or Grandchild of Arme: Last ederally Recognized To State St	f an Enrolled Member of a Fe First ribe: M.I. City Reside with you? Yes	Enrollment N State	Full Middle umber: Social Security Number Zip Full Time Student?	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address: Birth Date: Relationship:	Child or Grandchild of Ame: Last Ederally Recognized To Street Child Step Child	First ribe: M.I. City Reside with you? Yes Do you claim on Taxes? Name of School	Enrollment N State	Full Middle umber: Social Security Number Zip Full Time Student?	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address: Birth Date: Relationship:	Child or Grandchild of Ame: Last Ederally Recognized To Street Street Child Step Child Grandchild CTRIBAL ENROLLMENT Indant: Enrolled in a Federall	First ribe: M.I. City Reside with you? Yes Do you claim on Taxes? Name of School INFORMATION	Enrollment N State No Yes No	Full Middle lumber: Social Security Number Zip Full Time Student? Yes **If student please provide sch	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address: Birth Date: Relationship: DEPENDANT	Child or Grandchild of Ame: Last Ederally Recognized To The Control of Ame: TINFORMATION Last First Street Child Step Child Grandchild TINFORMATION Street Child Step Child Grandchild TINFORMATION Child Grandchild TINFORMATION	First ribe: M.I. City Reside with you? Yes Do you claim on Taxes? Name of School INFORMATION y Recognized Tribe	Enrollment N State No Yes No	Full Middle lumber: Social Security Number Zip Full Time Student? Yes **If student please provide sch	☐ Male ☐ Female		
Enrollee Na Name of Fe DEPENDANT Name: Address: Birth Date: Relationship: DEPENDANT Is your Depen	Child or Grandchild of Ame: Last Ederally Recognized To The Control of Ame: TINFORMATION Last First Street Child Step Child Grandchild TINFORMATION Street Child Step Child Grandchild TINFORMATION Child Grandchild TINFORMATION	First ribe: M.I. City Reside with you? Yes Do you claim on Taxes? Name of School INFORMATION y Recognized Tribe	Enrollment N State No Yes No	Full Middle lumber: Social Security Number Zip Full Time Student? Yes **If student please provide sch	Male Female No nool name below.		
Enrollee Na Name of Fe DEPENDANT Name: Address: Birth Date: Relationship: DEPENDANT Is your Depen Enrollee Na	Child or Grandchild of Ame: Last Ederally Recognized To Street Street Child Step Child Grandchild TRIBAL ENROLLMENT Indant: Enrolled in a Federall Child or Grandchild of Ame:	First Tibe: M.I. City Reside with you? Yes Do you claim on Taxes? Name of School INFORMATION y Recognized Tribe f an Enrolled Member of a Fe	Enrollment N State No Yes No	Full Middle Social Security Number	Male Female No nool name below.		

DEPENDANT	T INFORMATION					
Name:						
				Social Security Number		
	Last First	M.I.				
Address:					☐ Male	
	044	0"	0(:1:	7'	Female	
Birth Date:	Street	City	State		Ne	
Diffit Date.		Reside with you? Yes Do you claim on Taxes?	☐ No☐ Yes ☐ No	Full Time Student? Yes **If student please provide school	No I name below	
Dalatianakia	Child Step Child			II student please provide school	name below.	
Relationship:	Grandchild	Name of School				
DEPENDANT		INFORMATION				
DEPENDANT TRIBAL ENROLLMENT INFORMATION						
Is your Deper	ndant: 🔲 Enrolled in a Federal	ly Recognized Tribe	Non-Tribal Af	ffiliated		
	Child or Grandchild o	f an Enrolled Member of a Fe	ederally Recognized	Tribe		
Enrollee Na	ame:					
	Last	First	T	Full Middle		
Name of Fe	ederally Recognized T	ribe:	Enrollment N	lumber:		
DEDENIDANI	INFORMATION					
Name:	INFORMATION			I		
inaille.				Social Security Number		
	Last First	M.I.		Coolar Coounty Humbon		
Address:					Male	
					Female	
	Street	City	State	Zip		
Birth Date:		Reside with you? Yes		Full Time Student? Yes	No	
		Do you claim on Taxes?	☐ Yes ☐ No	**If student please provide school	name below.	
Relationship:	☐ Child ☐ Step Child	Name of School				
	Grandchild					
DEPENDANT	TRIBAL ENROLLMENT	INFORMATION				
ls vour Dener	ndant: Enrolled in a Federall	ly Recognized Tribe	☐ Non-Tribal At	ffiliated		
lo your Bopor		f an Enrolled Member of a Fe				
Enrollee Na	ame:					
	1	Fire		E HACLE.		
Name of E	Last ederally Recognized T	ribo:	Enrollment N	Full Middle		
Name of Fe	sucially Necognized 1	iibe.	Linominenti	diliber.		
DEPENDANT	INFORMATION					
Name:						
				Social Security Number		
	Last First	M.I.				
Address:					∐ Male	
	Street	City	State	Z ip	Female	
Birth Date:	Street	Reside with you? Yes		<u> </u>	No	
Birtir Bate.		Do you claim on Taxes?	Yes No	**If student please provide school		
Relationship:	Child Step Child	Name of School				
Grandchild Transcript Grandchild						
DEPENDANT TRIBAL ENROLLMENT INFORMATION						
Is your Dependant: Enrolled in a Federally Recognized Tribe Non-Tribal Affiliated						
Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe						
Enrollee Na		L c c. r ichiber of a r				
	Last	First	1=	Full Middle		
Name of Fe	ederally Recognized T	ribe:	Enrollment N	lumber:		

Section E

CURRENT SE	CONDA	RY AND PREVI	OUS COVERAGE					
		family member li the last 63 days		n, have current s If YES please fully	-	ealth coverage or had previous following section		
			mily member applying t	or coverage and	include info	rmation for all current		
and previous c	overage	in effect during	the last 18 months.					
Member Name			ance Company nd Claim Address)	Policy Number	Coverage Dates	Reason for Coverage Termination		
		(Name a	nd Claim Address)	Number	Dates	remination		
MEDICARE IN	NFORM!	ATION						
				П., П				
Are you or your s	spouse/ d	omestic partner co	overed by Medicare?	∐ Yes ∐	No If YES plea	ase complete the following selection		
Employee:	Part A	Effective Date		Spouse/ Domestic	Part A Effective Date			
	Part B	Effective Date		Partner:	Part B Effective Date			
	Part D	Effective Date		_	Part D Effective Date			
			ormation in this appli	cation may resu	It in the den	nial of claims or		
cancellation of coverage.								
Employee Signature Date Signed								
THIS PART TO	O BE CO	MPLETED BY 1	BENEFITS OFFICE					
Employee Date of Full-Time E		Employment Hourly Wage		Hours worked per week		Plan Number		
						767000415580		
Indicate the re	ason er	nnlovee is enro	Illing for coverage:					
				Return from leave	e of absence (le	ength of absence)		
☐ Previously waived coverage ☐ Change from part-time to full-time ☐ Other								
Date of event								
I certify the above information to be true and correct								
Benefit Clerk Signature Date								