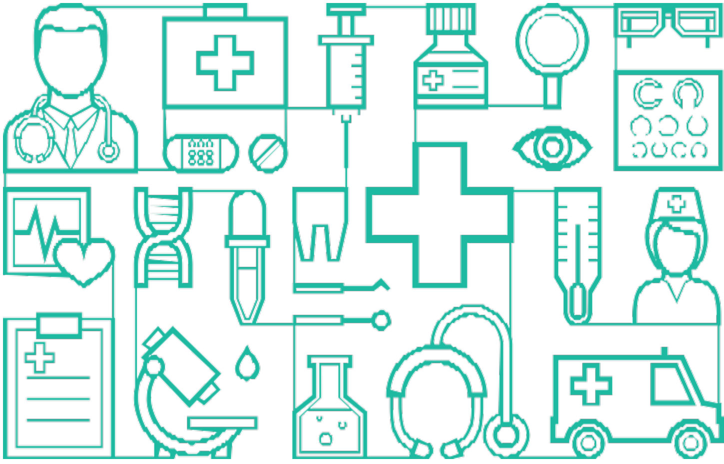

2020 Benefits at-a-Glance

Welcome to the 2020-2021 employee benefits program!

Dear plan participant:

Thank you for choosing your benefits through Elevanta Health. We are so excited to have you in the program and know you will see the value and care in your plan selection. **Your policy year with** <COMPANY> **will begin May 1, 2020 and run through April 30, 2021.**

Highlights for the 2020-2021 plan year include:

- All Elevanta Health major medical, MEC, HSA and dental plans utilize the Blue Cross Blue Shield PPO provider network, which covers 98 percent of physicians across the country.

- All major medical and MEC plans utilize Magellan Rx to process your prescription drug claims. A mail order drug program is also available through this provider. Enrollment information will be mailed to you separately from this packet if you are enrolled in a medical plan.

- The vision program will utilize the Spectera/United HealthCare network of providers. **No ID card will be mailed to you.** You may print an ID card online or simply provide your DOB to the providers to verify coverage and benefits.

- Teledoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. If you are currently enrolled in a major medical plan (Not an MEC plan) then Teladoc is included at no additional cost. If you are not enrolled in major medical and would like to enroll in Teladoc, the cost is $2.90 monthly. Please confirm this price with your employer. This price remains $2.90 no matter how many dependents you elect to enroll under you.

Included in this packet you will find:

- Important contact information
- Benefits-at-a-Glance
- Who's covered in your plan selection
- When you can make changes to your coverage
- What preventive care services you can take advantage of free-of-charge

Please remember: After your open enrollment, you will not be able to make any changes to your benefit selections until next year's open enrollment for the plan year beginning May 1, 2021, unless you have an IRS-recognized qualifying event.

If you have questions concerning your coverage, your Elevanta Health Benefits Service Team is here to assist you Monday through Friday from 8:30 a.m. to 5 p.m. EST.

Warmest Regards,

Your Elevanta Health Benefits Team
1701 Barrett Lakes Blvd, Ste. 180
Kennesaw, GA 30144
(e) health@elevanta.com
(p) 866-696-3225 (f) 866-632-9373

ELEVANTA
HEALTH

Who can I contact about my benefits?

If you need personal assistance or have a general question about your employee benefits, please contact:

	Elevanta Health	Medical and Dental	RX/ Medication	Vision
	Contact: **Elaina Chimeno** **Mara Hamlin** **Shameka Porter** **Jarmottie Miller**	Contact: **CBA Blue (Blue Cross Blue Shield)**	Contact: **Magellan Rx –** pharmacy vendor PCN: **CBG** BIN: **017449**	Contact: **United Healthcare (Spectera)**
	Phone: **1-866-696-3225**	Phone: **1-888-222-9206** Group Number: 50704	Phone: **1-800-424-0472**	Phone: **1-800-638-3120** Group Number: 729572
	Website/email: health@elevanta.com elevantahealth.com/employees	Website/email: select.cbabluevt.com provider.bcbs.com	Website/email: magellanrx.com – features drug and formulary list	Website/email: myuhcvision.com

Elevanta Health website

The Elevanta Health website, www.elevantahealth.com , offers quick and easy access to medical, dental, and vision summary plan descriptions (SPD). You can also find a uniform glossary of terms commonly used regarding health plan coverage, as well as other helpful forms and documents.

Medical and Dental Plan websites

Information on local Medical and Dental providers can be found by going to https://provider.bcbs.com. Put in your location and the 3-letter prefix for **YOUR PLAN** is **NFI**. You can search by Category, Specialty, Name, or Facility.

Many BCBS dentists participate in the **GRID** program. It's a program that enables dentists to see patients from other participating Blue Cross Blue Shield plans at their local-plan reimbursement levels. If you cannot locate your dentist at https://provider.bcbs.com , try going to the GRID lookup site at https://provider.cbabluevt.com/dental/search-dental-providers.aspx and look for your dentist there.

Vision Plan website

Vision Coverage is through United Healthcare which does not issue cards. You can locate providers by going to www.myuhcvision.com or calling (800) 638-3120. You can also print cards from the website once you register.

Benefits at-a-Glance

This is a general summary of benefits. If there are discrepancies between this information and the plan document, the information in the plan document prevails.

Benefit Plan	Eligibility	New Hire Waiting Period
Major Medical and MEC Choice	1. Salaried Employees 2. Full-time hourly (*working 30 hours or more) 3. Not offered to part-time employees	Eligible on the 1st of the month following 60 days of employment
Dental, Vision, and MEC Basic	1. Salaried Employees 2. Full-time hourly (*working 30 hours or more) 3. Part-time employees working 20 hours	Eligible on the 1st of the month following 60 days of employment
Supplemental Life	1. Salaried Employees 2. Full-time hourly (*working 30 hours or more) 3. Not offered to part-time employees	Eligible on the 1st of the month following 60 days of employment
Supplemental AD&D	1. Salaried Employees 2. Full-time hourly (*working 30 hours or more) 3. Part-time employees working 20 hours	Eligible on the 1st of the month following 60 days of employment

***As determined and measured by employer.**

Medical Questionnaire

A completed medical questionnaire is required for employees that are new to the Elevanta Health program or any employee who wishes to add new dependents to their existing coverage. **Please note:** Your employer may not offer the dental, vision, supplemental life and/or AD&D plans above. Please check with your employer or call the Elevanta Health Service Center to see if dental, vision, supplemental life and/or AD&D benefits are available.

Providers

Major medical and MEC benefits are offered through a self-funded program sponsored by your employer. Participating physician, hospital, prescription drug and dental program information can be obtained via http://provider.bcbs.com

Vision insurance program is offered through United HealthCare. Search for providers by calling 800-839-3242 or visiting www.myuhcvision.com.

Life insurance programs are offered through CIGNA.

Pre-tax Payroll Deductions

All employee contributions will be automatically made on a pre-tax basis. The Medical Plans are offered on a pretax basis through the IRS Section 125. By taking your contributions on a pretax basis, the premium is withheld from your pay before federal, state (in most cases), and FICA taxes are calculated. This can reduce the amount of taxes withheld from your paycheck.

Who’s covered in my plan?

Employee

If you are a full-time employee working a minimum of 30 hours per week, you are eligible for the benefits offered by your employer, which become effective on the 1st of the month following 60 days of full-time employment.

If you are a part-time employee working 20 hours minimum per week, you are eligible for MEC Basic, Dental, Vision and Supplemental AD&D, if offered by your employer.

Eligible dependents including your **legal spouse** and your **dependent child(ren)**.

Dependent child(ren) include:

- Natural children
- Legally adopted children or children placed for adoption for whom legal adoption proceeding have been started
- Stepchildren
- Children for whom benefits must be provided through a qualified Medical Child-Support Order
- Any other child for whom you have obtained legal guardianship

Regardless of marital status, children are eligible for medical coverage from birth until the end of the month of their 26th birthday. If a child becomes mentally or physically disabled while covered under the benefit plans, the child’s coverage may be continued if the child remains disabled and depends on you for support.

Coverage terms to understand:

The term “**legal spouse**,” as used above: an eligible employee's same or opposite-sex spouse, provided that such individual is legally recognized as the eligible employee's spouse in any jurisdiction (such as a State or foreign country), and even if the individual is not recognized as the eligible employee's spouse in the employee's State of residence.

The word “**child**,” as used above: will include an eligible employee’s natural child, a legally adopted child (including a child in the custody of the employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child, or a child for whom legal guardianship has been granted, but excludes a child who is eligible for employee coverage under this Plan.

Full-time employee: A person directly employed in the regular business of, and compensated for, services by the Company, who is employed on average at least 30 hours of service per week. This definition specifically excludes independent contractors. Notwithstanding the foregoing, to the extent that an employee qualifies as a full-time employee as defined under Section 4980H(c)(4) of the Internal Revenue Code, such employee will be treated as being in an eligible class.

ELEVANTA HEALTH

When can I make a change to my coverage?

The Elevanta Health Program has established a plan that allows the deductions for health care costs to be made on a pre-tax basis. This is a Flexible Benefits Plan and it effectively decreases your cost of the PPO plans, MEC plans, dental plans, vision plan, and supplemental life.

Making Coverage Changes During the Year

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment in May unless you have a qualifying life event or your eligible dependents become eligible for coverage through special enrollment rules.

Qualifying life events include, but are not limited to:

Birth or adoption of an eligible child.

Gain or loss of dependent status: child reaches age limit for eligibility.

Marriage, divorce or legal separation.

Residence or workplace change that impacts your or your dependent's eligibility for coverage.

Employment status change: starting or ending employment, for you, your spouse or your child(ren).

Death of a spouse or dependent.

If you experience a qualifying event, you must notify your employer AND contact Elevanta Health within 30 days of the qualifying event and provide appropriate documentation. **For a more complete list of qualifying life events and special enrollment rules, refer to the Summary Plan Description.**

Enrollment and changes for these plans are allowed at the following times only:

- Within 60 days from date of hire or date you moved into an eligible class.
- During the annual open enrollment period each year.
- When a change in the family status occurs—changes to insurance as well as supporting documentation must be received by the Elevanta Health Service Center **within 30 days** of change in family status.

Cafeteria 125 IRS qualifying event changes in family status:

- Marriage or divorce.
- Death of spouse or dependent.
- Birth or adoption of child.
- Termination or commencement of spousal health benefits.
- Going from part-time status to full time or from full-time status to part time.
- You or your spouse take an unpaid Leave of Absence.

Any change in coverage due to a change in family status must be necessary or appropriate as a result of that change in family status.

When coverage ends

Medical, dental, vision, supplemental and other coverage for you and your covered dependents normally ends on the date following:

- Termination of your employment for any reason.
- Loss of eligibility for you or your dependents.
- The end of the month of your dependent child's 26th birthday.
- The cessation of your contributions.
- Cancellation of coverage by the company.

What preventive care services are covered?

In order to prevent illness and disease, as well as minimizing health care costs, all Elevanta Health plans, including the Minimum Essential Coverage (MEC) plans, cover a list of preventative services at no out-of-pocket cost to members. That means no copayments, coinsurance or deductibles. This applies only when these services are delivered by an in-network provider.

Preventative Care Services covered 100% include:

Adults

1. **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
2. **Alcohol Misuse** screening and counseling
3. **Aspirin** use to prevent cardiovascular disease for men and women of certain ages
4. **Blood Pressure Screening** for all adults
5. **Cholesterol Screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer Screening** for adults over 50
7. **Depression Screening** for adults
8. **Diabetes (Type 2) Screening** for adults with high blood pressure
9. **Diet Counseling** for adults at higher risk for chronic disease
10. **Falls Prevention** (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
11. **Hepatitis B Screening** for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S. – born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. **Hepatitis C Screening** for adults at increased risk, and one time for everyone born 1945 – 1965
13. **HIV** screening for everyone ages 15 to 65, and other ages at increased risk
14. **Immunization** vaccines for adults (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella)
15. **Lung Cancer Screening** for adults 55 – 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
16. **Obesity** screening and counseling for all adults
17. **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
18. **Statin Preventative Medication** for adults 40 to 75 at high risk
19. **Syphilis** screening for all adults at higher risk

20. **Tobacco Use Screening** for all adults and cessation interventions for tobacco users
21. **Tuberculosis Screening** for certain adults without symptoms at high risk

Women, including pregnant women

1. **Anemia Screening** on a routine basis for pregnant women
2. **Breastfeeding** comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt “religious employers”
4. **Folic Acid Supplements** for women who may become pregnant
5. **Gestational Diabetes Screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. **Diabetes Screening** for women with a history of gestational diabetes who aren’t currently pregnant and who haven’t been diagnosed with type 2 diabetes before
7. **Gonorrhea screening** for all women at higher risk
8. **Hepatitis B screening** for pregnant women at their first prenatal visit
9. **Preeclampsia Prevention and Screening** for pregnant women with high blood pressure
10. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
11. **Syphilis** screening for all pregnant women or other women at increased risk
12. **Expanded Tobacco Intervention and Counseling** for pregnant tobacco users
13. **Urinary tract** or other infection screening for pregnant women
14. **Breast Cancer Genetic Test Counseling (BRCA)** risk assessment and genetic testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
15. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
16. **Breast Cancer Chemoprevention** counseling for women at higher risk
17. **Breast cancer risk-reducing medications**, such as tamoxifen or ralozifene, for women who are at increased risk for breast cancer
18. **Cervical Cancer** screening for sexually active women. Pap test (also called a Pap smear) every 3 years for women 21-65; Human Papilomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30-65 who don’t want a Pap smear every 3 years
19. **Chlamydia** Infection screening for younger women and other women at higher risk
20. **Domestic and interpersonal violence** screening and counseling for all women
21. **Osteoporosis** screening for women over age 60 depending on risk factors
22. **Urinary incontinence screening** for women yearly
23. **Well-woman visits** to get recommended services for women under 65

Children

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism** screening for children at 18 and 24 months
3. **Behavioral assessments** for children at the following ages: 0–11 months, 1–4 years, 5–10 years, 11–14 years, 15–17 years.
4. **Bilirubin Concentration Screening** for newborns
5. **Blood Pressure** screening for children at the following ages: es: 0–11 months, 1–4 years, 5–10 years, 11–14 years, 15–17 years.
6. **Blood Screening** for newborns
7. **Cervical Dysplasia** screening for sexually active females
8. **Depression** screening for adolescents
9. **Developmental** screening for children under age 3
10. **Dyslipidemia** screening for children at higher risk of lipid disorders at the following ages: 1–4 years, 5–10 years, 11–14 years, 15–17 years.
11. **Fluoride Chemoprevention** supplements for children without fluoride in their water source
12. **Fluoride Varnish** for all infants and children as soon as teeth are present
13. **Gonorrhea** preventive medication for the eyes of all newborns
14. **Hearing** screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. **Height, Weight and Body Mass Index** measurements for children at the following ages: es: 0–11 months, 1–4 years, 5–10 years, 11–14 years, 15–17 years.
16. **Hematocrit or Hemoglobin** screening for children
17. **Hemoglobinopathies or sickle cell** screening for newborns
18. **Hepatitis B Screening** for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.–born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11–17 years
19. **HIV** screening for adolescents at higher risk
20. **Hypothyroidism** screening for newborns
21. **Immunization Vaccines** for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis (Whooping Cough); Haemophilus influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Pneumococcal; Rotavirus; Varicella (Chickenpox)
22. **Iron supplements** for children ages 6 to 12 months at risk for anemia
23. **Lead** screening for children at risk of exposure
24. **Maternal Depression Screening** for mothers of infants at 1, 2, 4, and 6–month visits

25. **Medical History** for all children throughout development at the following ages: es: 0–11 months, 1–4 years, 5–10 years, 11–14 years, 15–17 years.
26. **Obesity** screening and counseling
27. **Oral Health risk** assessment for young children Ages: es: 0–11 months, 1–4 years, 5–10 years.
28. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
29. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
30. **Tuberculin** testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
31. **Vision s**creening for all children.

1701 Barrett Lakes Blvd. NW, Ste. 180
Kennesaw, GA 30144
Phone: 866-696-3225
Fax: 866-632-9373
Email: health@elevanta.com

2020-2021 BENEFIT ENROLLMENT FORM

EFFECTIVE DATE:______/_____/_____ COMPANY NAME: <COMPANY>________

☐ ANNUAL (OPEN) ENROLLMENT

☐ CHANGE (QUALIFYING EVENT) – REASON:____ DATE OF EVENT:____/____/____

☐ NEW EMPLOYEE – DATE OF HIRE:______/_____/_____

EMPLOYEE NAME (LAST, FIRST, MI)					SOCIAL SECURITY NUMBER	
MAILING ADDRESS					DATE OF Birth	
CITY		STATE	ZIP	PHONE NUMBER		
DATE OF HIRE	TITLE	EMAIL ADDRESS			GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ MARRIED ☐ SINGLE

MEDICAL INSURANCE (CBA Blue - Blue Cross Blue Shield)

CHECK ONE:			
☐ Silver Choice	☐ MEC Choice		
Select Level of Medical Coverage **All medical elections include a $10,000 Term life + AD&D policy			
☐Employee Only	☐Employee/Spouse	☐Employee/Children	☐Employee/Family
☐**Waive/Refuse Medical**			

TELADOC *$2.90 for those NOT enrolled in major medical.	VISION (UNITED HEALTHCARE - SPECTERA)	DENTAL HIGH / LOW (CBA BLUE – BLUE CROSS BLUE SHIELD)
CHECK ONE	CHECK ONE	CHECK ONE
☐Enroll	☐ Employee Only	☐ Employee Only
	☐Employee/Spouse	☐Employee/Spouse
	☐Employee/Children	☐Employee/Children
	☐Employee/Family	☐Employee/Family
☐**Waive Teladoc**	☐**Waive Vision**	☐**Waive Dental**

SUPPLEMENTAL LIFE INSURANCE (not available to part-time employees)		
Employee Life: ☐ Guaranteed Issue Amount: $50,000 (New hires only) ☐ Other Amount: $__________ (Up to - $100,000 max) **MEDICAL QUESTIONNAIRE REQUIRED	**Spouse Life:** ☐ Guaranteed Issue Amount:$10,000 (New hires only) ☐ Other Amount: $ ______________ (Up to 50% employee coverage – $50,000 max) **MEDICAL QUESTIONNAIRE REQUIRED	**Child(ren) Life:** ☐ Benefit Amount:_______________ (Up to age 25) $5,000 / $10,000
☐**Waive Employee Voluntary Life**	☐**Waive Spouse Voluntary Life**	☐**Waive Child(ren) Voluntary Life**

2020-2021 BENEFIT ENROLLMENT (PG.2)

AD&D INSURANCE (CIGNA Life)		
Employee AD&D: ☐ Amount: $___________________ (Up to - $100,000 max / increments of $10,000)	**Spouse AD&D:** ☐ Amount: $ ______________________ (Up to 50% employee coverage – $50,000 max)	**Child(ren) AD&D:** ☐ Benefit Amount: $_________________ (Up to age 25 – 25k max / increments of $5,000)
☐ **Waive Employee AD&D**	☐ **Waive Spouse AD&D**	☐ **Waive Child(ren) AD&D**

DEPENDENT INFORMATION

Typically, legal spouse; dependent children under age 26, including natural children, legally adopted children, stepchildren, foster children or any other children for whom you have been designated as legal guardian. Coverage ends the last day of the month in which they reach age 26. Stepchild(ren) must reside with you and rely on you for support and maintenance to be eligible.

*** * Children of any age if unmarried, incapacitated and unable to care for self, if the incapacity occurred before age 26.**

DEPENDENT NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	ADD / DROP COVERAGE?
	SPOUSE	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc
	CHILD	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc ☐ **Disabled child over age 26****
	CHILD	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc ☐ **Disabled child over age 26****
	CHILD	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc ☐ **Disabled child over age 26****
	CHILD	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc ☐ **Disabled child over age 26****
	CHILD	☐ MALE ☐ FEMALE			☐ Add Coverage ☐ Drop Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Teladoc ☐ **Disabled child over age 26****

SIGNATURE

AUTHORIZATION

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that:

1. Medical, dental and vision insurance deduction amounts are taken "before tax" and I benefit from tax advantages of this arrangement and, therefore, my gross salary for FICA will be reduced and my Social Security Retirement Benefit may be affected.
2. My elections cannot be changed until the next annual enrollment, unless I have an IRS qualified change in status such as marriage, divorce, death, birth, change in child's dependent or student status or in my or my spouse's employment status, or loss of spouse's health coverage. If I want to change my elections due to a qualified change in status event, I must provide a new enrollment form to Human Resources within 30 days of the effective date of the status change.
3. I have received the Benefits Summary booklet and enrollment information indicating the benefit options available to me.
   This enrollment form does not constitute an employment or insurance contract.
4. I have read and understand all insurance plan restrictions, limitations, and exclusions (if applicable).
5. I understand the MEC Basic plan provides less coverage than traditional major medical programs and may not be suitable for everyone. Please review the details of the MEC Basic or Choice plan before choosing it. Please initial here to acknowledge you have read the above statement. _________

EMPLOYEE SIGNATURE / DATE :

Life Insurance Company of North America

Group Name Elevanta Health **Life Insurance Policy Number** FLX980104 **AD&D Policy Number** OK890145

Company Name: ____________________

BENEFICIARY DESIGNATION

Note: The designation(s) on this form will remain in effect until changed in writing by completing a new Beneficiary Designation Form.

PRIMARY BENEFICIARY(IES): Percentages of your primary beneficiary(ies) must equal a total of 100%

POLICY	BENEFICIARY NAME	SOCIAL SECURITY	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					

CONTINGENT BENEFICIARY(IES): Percentages of your contingent beneficiary(ies) must equal a total of 100%

POLICY	BENEFICIARY NAME	SOCIAL SECURITY	DATE OF BIRTH	RELATIONSHIP	BENEFIT%
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					
☐LIFE ☐AD&D ☐BOTH					

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature **Date** / /

Owner Signature **Date** / /

If you need additional space, using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]." If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Elevanta Health Group Health and Dental Questionnaire

***Please complete and sign both pages in their entirety.**

❑ NEW HIRE ❑ LATE ENROLLEE ❑ WAIVER ❑ SPECIAL ENROLLEE		Effective Date / /	Plan Election

A. Enrollment Information

Name (First, Last, Middle Initial)	Social Security Number	Soc. Sec. Disabled? ❑ Yes ❑ No	Medicare Enrolled? ❑ Yes ❑ No	‰ Male ‰ Female	Birthdate	Height	Weight

Address (Include Street, Building Name/Number, Apartment Number, City, State, Zip Code)	County	Telephone ( )	Marital Status: ❑ Single ❑ Married

Employer Name and Address	Employment Type ❑ Salaried ❑ Hourly	Hire Date	Salary Amount $_____/year $_____/hour	Employment Status ‰ Full-Time ‰ Retiree ‰ Part-Time ‰ COBRA

B. Coverage Information: Please indicate which eligible coverage(s) you are choosing. Please check only one type of coverage per product.

Medical:	❑ Employee	❑ Employee/Spouse	❑ Employee/Child(ren)	❑ Employee/Spouse/Child(ren)
Dental:	❑ Employee	❑ Employee/Spouse	❑ Employee/Child(ren)	❑ Employee/Spouse/Child(ren) Dental:

Name (First, Last, Middle Initial) List all persons to be covered excluding applicant.	Birthdate	Social Security Number	Gender	Height	Weight	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			❑ M ❑ F				❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No

C. Medicare Coverage

Name of covered person:	Medicare ID (HIC) No.:	Eligibility Date / Effective Date (Part A): Eligibility Date / Effective Date (Part B):

D. Other Carrier Information	E. Prior Coverage Information
❑ Yes ❑ No Will you, your spouse or your dependents keep other health coverage in addition to this Elevanta Health coverage? If yes, please complete the following section.	❑ Yes ❑ No New Hire: Did you, your spouse or dependents have coverage within 63 days prior to the hire date stated above? ❑ Yes ❑ No Special Enrollee/Late Enrollee: Did you, your spouse or dependents have health coverage within 63 days prior to the effective date of this coverage? Complete the following section.
Name (First, Last, Middle Initial)	Name of Covered Person(s):
Employer (if applicable)	Employer (if applicable)
Insurance Company/HMO Name and Address	Insurance Company/HMO Name and Address

Policy No.	Contract Type ❑ Single ❑ Family ❑ 2-Person	Effective Date	Policy Number	Contract Type ❑ Single ❑ Family ❑ 2-Person	Effective Date	End Date

F. Waiver (Please complete if you are declining_____Health coverage_____Dental coverage.)

❑ I decline coverage for me and all my dependents. Please check all that apply:

I (We) have other coverage through: spouse's employer parent/guardian's employer individual policy Medicare Medicaid Indian Health Service Tricare

❑ Other reason for declining coverage (please explain):

Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your Dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependent(s)' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent(s) as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Employee Signature ____ Date ____________________

*The statements and answers set forth must be full, true, and correct to the best of the applicant's knowledge and belief and that no information required to be given, either expressly or by implication, has been knowingly withheld. If false statements or misrepresentations are made, fail to be disclosed or any material fact concealed, the Plans will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person there under.

Employee Name:

***Please complete and sign both pages in their entirety if applying for medical or dental coverage.**

G. Health Questions- Please answer all questions. If yes, please explain in section H below.

- ❑ Yes ❑ No In the last year, has anyone received medical treatment apart from routine physicals or inoculations? **(If yes, list in section below.)**
- ❑ Yes ❑ No Do you or your dependent(s) take any medicine, drugs, pills or require shots? **(If yes, list in section below.)**
- ❑ Yes ❑ No Do you or your dependent(s) have treatments, tests, hospitalization or surgery planned in the future? **(If yes, list in section below.)**
- ❑ Yes ❑ No Is anyone applying for coverage currently pregnant? **Estimated due date ___/___/_____**
- ❑ Yes ❑ No Is anyone applying for coverage currently a tobacco user? **(If yes, please list applicant name below.)**

The following health questions pertain to your health coverage only and will be used to assess your employer health coverage risk. If you, or any person named in this application, has been diagnosed or treated in the last **10 years** for any of the conditions listed below, **please put an "X" in the box, and explain in Section H below.**

- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Back/Spinal Disorder
- ❑ Back strain/Sprain
- ❑ Scoliosis
- ❑ Spinal Bifida
- ❑ Stroke
- ❑ Cancer, Leukemia, Melanoma
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Asthma
- ❑ Other Lung Disorder
- ❑ Liver Disorder
- ❑ Congenital Disease/Defect
- ❑ Paralysis
- ❑ Multiple Sclerosis
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Parkinson's
- ❑ Alzheimer's Disease
- ❑ Other Neurological Disease
- ❑ Hemophilia
- ❑ Kidney/Urinary Disorder
- ❑ Tumor/Growths
- ❑ Juvenile Diabetes
- ❑ Diabetes Mellitus
- ❑ Heart Attack/M.L.
- ❑ Coronary Artery Disease
- ❑ Bypass Surgery
- ❑ Congestive Heart Failure
- ❑ Pacemaker
- ❑ Ischemic Heart Disease
- ❑ Other Heart Disorders
- ❑ High Blood Pressure
- ❑ Alcohol or Drug Dependency
- ❑ Attempted Suicide
- ❑ Anorexia/Bulimia
- ❑ Chronic Depression
- ❑ Other Mental/Behavioral Disorder
- ❑ Venereal Disease/STD
- ❑ Deafness
- ❑ Ulcerative Colitis
- ❑ Diverticulitis
- ❑ Past Transplant or Current Transplant Waiting List
- ❑ Crohn's Disease
- ❑ Gastric/Peptic Ulcer
- ❑ Other Bowel/Stomach Disorder
- ❑ Premature Birth

IDENTIFY ANY OTHER CONDITIONS

- ❑ Other ______________________
- ❑ Other ______________________
- ❑ Other ______________________
- ❑ Other ______________________

List any other condition, treated in the last 10 years, not mentioned above:

H. Health Statement **(If you checked any of the health questions or listed any other conditions on this form, please complete this section.** Use additional pages if needed and include your signature and date.)

Name of Person	Condition	Date Diagnosed	Dates Treated	Type of Treatment/ Names of Medications	Are Medications Ongoing?	Is Treatment Ongoing?

I. Authorization and Certification

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forthare full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Plans will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to discloseor concealed any material fact, the Plans will be entitled todeclare the contracts applied for void and to refuse allowance on benefits to any person there under.

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by NFA Health+ Incorporated Cell (NFAH+ IC). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Plans on my behalf. This authorization is to remain in effect until the Plans are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished by my employer as my agent. I further understand that the coverage's applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Plan and an effective date of coverage is established by the Plans.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Plans all health & mental records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. This information is being used to carry out pre-enrollment underwriting and is in force until that process is complete, at which time it expires. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Plans or Provider have relied on it in the use or disclosure of protected health information. This form does not authorize the re-disclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. NFAH+ IC maintains the confidentiality of all information received and it will not be released to any person or facility unless the individual is applying for coverage underwritten by NFA Health+ Incorporated Cell (NFAH+ IC) in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to NFA Health+ Incorporated Cell (NFAH+ IC). The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. I understand that I have the right to refuse to sign this authorization, but that the Plans then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I have read and understand the Authorization and Certification language above and acknowledge receipt of a fully completed copy of this application.

Employee Signature

Date / /