



MANATT'S INC. AND AFFILIATED CO.'S HEALTH ENROLLMENT FORM			
GROUP _____	SHADED AREAS TO BE COMPLETED BY EMPLOYER		
HIRE DATE	RETURN TO WORK DATE	EFFECTIVE DATE	EE NUMBER

<input type="checkbox"/> NEW/ORIGINAL ENROLLMENT	<input type="checkbox"/> CHANGE/SPECIAL ENROLLMENT	<input type="checkbox"/> SINGLE MEDICAL COVERAGE	<input type="checkbox"/> FAMILY MEDICAL COVERAGE	<input type="checkbox"/> DECLINE MEDICAL COVERAGE
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NOTE: PLEASE READ BOTH SIDES AND COMPLETE THIS FORM

NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS

EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET/MAILING ADDRESS		
CITY, STATE, ZIP	SEX	HOME PHONE #
MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED	FULL TIME HIRE DATE	

MEDICAL COVERAGE REQUEST: -EMPLOYEE/SINGLE -FAMILY SPOUSE ACCORDING TO IOWA CODE 595

I DECLINE MEDICAL COVERAGE FOR: -MYSELF AND MY ELIGIBLE DEPENDENTS -MY SPOUSE -MY DEPENDENTS

I have been given the opportunity to participate in the group healthcare plan offered by my employer and I decline participation for:

Myself And My Eligible Dependents: Names: _____

My Eligible Dependents: Names: _____

DEPENDENT INFORMATION: PLEASE COMPLETE FOR ALL DEPENDENTS COVERED BY THIS REQUEST					DOES DEPENDENT HAVE OTHER MEDICAL COVERAGE? (YES OR NO) IF SO, INSURANCE COMPANY NAME
DEPENDENT NAME (FIRST AND LAST)	SEX M/F	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY #	
SPOUSE		SPOUSE			
1.					
2.					
3.					
4.					
5.					
6.					

ARE ANY DEPENDENTS AGE 19 AND OVER ATTENDING SCHOOL ON A FULL TIME BASIS? -YES -NO

DEPENDENT NAME/SCHOOL	DEPENDENT NAME/SCHOOL
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IS ANY DEPENDENT OR SPOUSE DISABLED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY)	NAME OF DISABLED DEPENDENT	TYPE OF DISABILITY/DATE DISABILITY BEGAN
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COMPLETE INFORMATION BELOW IF CHANGE IS BEING MADE AFTER INITIAL ENROLLMENT

CHANGE FROM SINGLE TO FAMILY COVERAGE	<input type="checkbox"/> MARRIAGE SEE IOWA CODE 595	<input type="checkbox"/> PLACEMENT FOR ADOPTION
DATE OF EVENT (MO/DAY/YR) _____	<input type="checkbox"/> BIRTH/ADOPTION	<input type="checkbox"/> LOSS OF COVERAGE, EXPLAIN _____
CHANGE FROM FAMILY TO SINGLE COVERAGE	<input type="checkbox"/> DIVORCE	<input type="checkbox"/> SPOUSE HAS OTHER INSURANCE
DATE OF EVENT (MO/DAY/YR) _____		<input type="checkbox"/> OTHER , EXPLAIN _____

ASSIGNMENT AND AUTHORIZATION

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S HEALTHCARE PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE, TO OR BY FIRST ADMINISTRATORS, INC. OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNT(S) AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS.

I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ON BOTH SIDES

EMPLOYEE SIGNATURE

DATE SIGNED

PLEASE READ BOTH SIDES OF THIS FORM

MANATT'S INC. AND AFFILIATED CO.'S

IMPORTANT INFORMATION: PLEASE READ

HEALTHCARE PREEXISTING CONDITION; SPECIAL ENROLLMENT PROVISION, DECLINATION AND CONTACT INFORMATION

PREEXISTING CONDITION EXCLUSION RULES

This plan imposes a preexisting condition exclusion. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan or who has creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 9 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 9-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SPECIAL ENROLLMENT PROVISION

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Medicaid or SCHIP: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while on Medicaid or SCHIP you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after you or your dependents lose that coverage.

Dependent Beneficiaries

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance under Medicaid or CHIP.

If the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP), you may be able to enroll yourself and your eligible dependents. You must request enrollment within 60 days.

DECLINATION OF COVERAGE

If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period (if applicable), unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption. Further, anyone whom you enroll during annual open enrollment will be treated as a "late enrollee" (unless that person happens to be entitled to special enrollment during the annual open enrollment period).

MY SIGNATURE ON PAGE ONE SERVES AS CONFIRMATION OF DECLINATION OF COVERAGE.

IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.

CONTACT INFORMATION

All questions about the preexisting condition exclusion and creditable coverage should be directed to Membership Representative, First Administrators, Inc., PO Box 9900, Sioux City, IA 51102-0479 or phone 1-800-206-0827.