MANATT'S, INC., AND AFFILIATES
BENEFIT ENROLLMENT FORM

☐ New Hire/Original Enrollment ☐ Open Enrollment
☐ Change in Status/Special Enrollment

OFFICE USE ONLY	Employer: MANATT'S, INC.	Hire/Rehire Date	Effective Date

1. Employee Information

First Name	MI	Last Name	Social Security Number	EE#
Mailing Address	City	State	Zip	Phone
Date of Birth	Gender ☐ Male ☐ Female	Marital Status	Position/Job Title	

2. Complete this section ONLY if electing dependent coverage. Refer to Summary Plan Description (SPD) for definition of eligible dependents.

	First, MI, Last Name	Social Security Number	Date of Birth	Gender
Spouse				☐ Male ☐ Female
Child				☐ Male ☐ Female
Child				☐ Male ☐ Female
Child				☐ Male ☐ Female
Child				☐ Male ☐ Female
Child				☐ Male ☐ Female

3. Benefit Elections

Medical Plan	☐ Single	☐ Family	☐ Decline Coverage		
Dental Plan	☐ EE Only	☐ EE/Spouse	☐ EE/Child(ren)	☐ Family	☐ Decline Coverage
Vision Plan	☐ EE Only	☐ EE/Spouse	☐ EE/Child(ren)	☐ Family	☐ Decline Coverage
Group Term Life Insurance (100% Company Paid)		☐ EE Only	☐ EE/Dependent		
Employee Voluntary Term Life Insurance ☐ Yes ☐ No			Tobacco User? ☐ Yes ☐ No		Indicate Benefit Amount $
Spouse Voluntary Term Life Insurance ☐ Yes ☐ No	Indicate Benefit Amount $		Child Voluntary Term Life Insurance ☐ Yes ☐ No		Indicate Benefit Amount $
Voluntary Long-Term Disability Insurance ☐ Yes ☐ No			Office Use Only Base Earnings Per Hour $		Base Earnings Per Week (Salaried Employee) $

4. Other Coverage – Complete ONLY if you or family member enroll in medical or dental coverage

Do you or any family member have other medical or dental coverage?	☐ Yes - Single	☐ Yes – Family	☐ No
If yes, complete the following: Person's Name(s)			
Employer Name	Insurance Company Name	Plan Number	

5. Beneficiary Designation

The primary beneficiary is the person(s) who receives the life insurance benefit if you die. The contingent beneficiary will be paid the benefit if there are no primary beneficiaries living at the time of your death. If more than one person is named as primary or contingent and the specific percentage has not been designated, each will receive an equal share of the benefit. I hereby make the following beneficiary designation:

	First, MI, Last Name	Social Security Number	Date of Birth	Relationship	% of Benefit
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

6. Complete this section ONLY if making changes to current benefit elections.

Date of Event		Reason for Change	Name of Affected Party
	☐	Marriage	
	☐	Birth/Adoption	
	☐	Placement for Adoption	
	☐	Spouse/Children Loss Coverage, Explain:	
	☐	Divorce/Legal Separation	
	☐	Spouse/Children Eligible for Other Coverage, Explain:	
	☐	Voluntary Termination	

7.Waiver of Coverage – Signature required if waiving health, dental or vision coverage

If you wish to enroll after your initial eligibility period, all coverage except health, dental and vision require evidence of insurability and may be denied. However, if you are declining or terminating enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage or if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself or your dependents, provided that you request enrollment within 31 days of the special enrollment event. Additional information about special enrollment events is provided below.

☐ I am terminating or declining because my dependents or I have other ☐ health, ☐ dental , ☐ vision coverage.

☐ I (we) do not have other ☐ health, ☐ dental, ☐ vision coverage, but am (are) terminating or declining coverage at this time.

I understand that by terminating or declining coverage at this time, I (we) may only be eligible to enroll during a special enrollment period as described above.

Signature **Date**

8.Insurance Agreement

I understand that if I have made any false statement or misrepresentations or have failed to disclose or concealed any material fact, benefits may be denied and/or coverage may be voided. I understand that any coverage applied for after my original eligibility date or in excess of the guaranteed issue amount will not begin until approved. I agree that any surgeon, physician, dentist, pharmacist, nurse, hospital or healthcare facility may furnish the diagnosis and/or any history of any past, present, or future treatments or conditions of all persons named herein. I agree, upon request, to furnish all information required to administer the health care plan. I hereby authorize my employer to make deductions from my wages for the cost of my benefits, if required. For benefits offered on a pre-tax basis, I understand that if I do not want my wages reduced on a pre-tax basis, I will need to contact my employer in writing.

Signature **Date**

PLEASE READ IMPORTANT INFORMATION BELOW:

Special Enrollment Provision

Loss of Other Coverage. If you decline enrollment for yourself or for any 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 your or your dependents' other coverage). However, you must request enrollment within 31 days after other coverage ends (or after the employer stops contributing toward the other coverage), except as provided below.

Medicaid or CHIP. If you or your dependent(s) lose coverage under Medicaid or a state Children's Health Insurance Program (CHIP) as a result of a loss of eligibility for such coverage, you may be able to enroll yourself and your dependents in this plan if you request coverage within 60 days after the date of termination or loss of eligibility under the state program. In addition, if you or your dependent(s) become eligible for a premium assistance subsidy under Medicaid or a state CHIP, you may be able to enroll yourself and your dependents in this plan if you request coverage within 60 days after the date of eligibility for the subsidy.

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 any other eligible dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.