

SIE Holdings, Inc.

Benefits Enrollment/Change Form

Employee Personal Information – All employees MUST complete this section, even if waiving ALL Coverages			
Employee Name (Last, First, Middle Initial)		Social Security #	Date of Birth
Home Address		City	State/Zip Code
Email Address	Phone Number	Marital Status	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Reason for Enrollment (Check all that apply)			
Enrollment Type <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Open Enrollment Effective Date: _____	Change Type <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Cancel Date of Change: _____	Reason for Change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Other Coverage Date of Event: _____	

Enrollee Information- *When electing coverage, please list yourself and ALL eligible dependents for whom you are electing ANY coverage, even if all dependents will not be covered on all plans														
Last Name	First Name	Date of Birth	SSN (Required)	Relationship	Gender	Coverage Elected (please 'X' if electing)								
						Medical	Dental	Vision	Life	Critical Illness	Accident	Hospital Indemnity		
				Self	<input type="checkbox"/> M <input type="checkbox"/> F									
				Spouse	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
				Child	<input type="checkbox"/> M <input type="checkbox"/> F									
MEDICAL/Rx - United Healthcare (UHC) – Choice Plus Network														
Rates listed below do not include Tobacco Free & Annual Physical Incentive Discounts available – Please refer to the Enrollment Guide for details														
Bi-Weekly Deduction & Election:			<input type="checkbox"/> EE only - \$36.73	<input type="checkbox"/> EE/Spouse - \$155.31	<input type="checkbox"/> EE/Child(ren) - \$114.76	<input type="checkbox"/> Family - \$204.57								
WAIVE/DECLINE COVERAGE:			<input type="checkbox"/> I DECLINE MEDICAL/Rx coverage for myself and all dependents (*see below)											

***If you are waiving** your right or your dependents' rights to coverage under the medical plan offered, you must declare the reason by checking one of the boxes below and **SIGN** where indicated below.

I understand failure to declare my reason for waiving coverage may limit my opportunity to join the plans later and could result in penalties based on Federal ACA requirements. I have been given the opportunity to participate in the benefit plans, but after due consideration, I have elected **NOT** to participate.

MY REASON FOR DECLINING MEDICAL/Rx COVERAGE IS:

Spouse's Plan
 Parent's Plan
 Individual Plan (Exchange or Marketplace)
 COBRA
 Medicare
 Medicaid
 Tricare
 VA Eligibility
 I do not have other coverage
 Other: _____

EMPLOYEE SIGNATURE: _____

DENTAL - Guardian				
Bi-Weekly Deduction & Election:	<input type="checkbox"/> EE only - \$2.67	<input type="checkbox"/> EE/Spouse - \$8.00	<input type="checkbox"/> EE/Child(ren) - \$8.86	<input type="checkbox"/> Family - \$13.26
WAIVE/DECLINE COVERAGE	<input type="checkbox"/> I DECLINE Dental coverage for myself and all dependents			

* If you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you experience a qualifying life event such as termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or children, provided you apply within 30 days.

VISION - Guardian				
Bi-Weekly Deduction & Election:	<input type="checkbox"/> EE only - \$0.60	<input type="checkbox"/> EE/Spouse - \$1.69	<input type="checkbox"/> EE/Child(ren) - \$1.38	<input type="checkbox"/> Family - \$2.17
WAIVE/DECLINE COVERAGE:	<input type="checkbox"/> I DECLINE Vision coverage for myself and all dependents			

EMPLOYER PAID BASIC LIFE AND AD&D – Guardian	
This benefit is 100% Employer paid. All eligible Full-Time employees are automatically enrolled in the coverage after 30 days of employment. Please refer to the Benefits Enrollment Guide for additional information, including reduction in coverage based on age and other limitations. Please provide your beneficiary designations in the space(s) below.	
<input checked="" type="checkbox"/> 3x annual salary to a maximum of \$200,000	

BASIC LIFE AND AD&D Primary Beneficiary(ies)			
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

BASIC LIFE AND AD&D Contingent Beneficiary(ies) In the event the primary beneficiaries are deceased, the contingent beneficiary(ies) will receive the benefit.			
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

EMPLOYEE PAID BASIC DEPENDENT LIFE – Guardian	
This benefit is 100% voluntary and paid by you, the employee. This benefit provides \$10,000 coverage for your legal Spouse and \$5,000 coverage for your Dependent Child(ren) age 14 days to 26 years. The employee is the beneficiary for this benefit, if elected.	
Bi-Weekly Deduction & Election:	<input type="checkbox"/> I elect Basic Dependent Life coverage - \$0.87
WAIVE/DECLINE COVERAGE:	<input type="checkbox"/> I DECLINE Basic Dependent Life coverage for all dependents

VOLUNTARY TERM LIFE – Guardian

This benefit is 100% voluntary and paid by you, the employee. If electing, please provide the amount of benefit you wish to purchase, as well as your beneficiary designations in the space below. Enrollment in this coverage is subject to full carrier guidelines. Completion of this application is not a guarantee of approval for coverage. Evidence of Insurability required for volumes requested over the Guaranteed Issue amount. Please refer to the Guardian Workplace Benefits materials for guarantees, limits, rates and options. Bi-weekly rates for employee and spouse depends on coverage amount elected and employee age bracket.

Employee Life Benefit Employee coverage must be elected in order to elect coverage for dependents. Available in increments of \$5,000 to a max of \$500,000. Guaranteed issue of \$130,000	Spouse Life Benefit Available in increments of \$5,000 to a max of \$100,000. May not exceed 100% of employee amount. Guaranteed issue of \$25,000.	Dependent Child(ren) Life Benefit Available in increments of \$1,000 to a max of \$10,000. May not exceed 100% of employee amount. Guaranteed issue of \$10,000
<input type="checkbox"/> I elect \$_____,000 Voluntary Life coverage	<input type="checkbox"/> I elect \$_____,000 Spouse Voluntary Life coverage	<input type="checkbox"/> I elect \$_____,000 Child(ren) Voluntary Life coverage

WAIVE/DECLINE COVERAGE:

I **DECLINE** Voluntary Term Life coverage for myself and all dependents

VOLUNTARY TERM LIFE Primary Beneficiary(ies)

Check here if same as Basic Life and AD&D Primary Beneficiary(ies)

Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

VOLUNTARY TERM LIFE Contingent Beneficiary(ies) In the event the primary beneficiaries are deceased, the contingent beneficiary(ies) will receive the benefit.

Check here if same as Basic Life and AD&D Contingent Beneficiary(ies)

Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

DISABILITY – Guardian

This benefit is 100% Employer paid. Employee is automatically enrolled once they satisfy the employee waiting period and meet the eligibility requirements to be considered eligible for this benefit. Please refer to the Benefits Enrollment Guide for additional information, including exclusions and limitations.

Short Term Disability (STD)	Long Term Disability (LTD)
Weekly Benefit: <input checked="" type="checkbox"/> 66.67% of salary to a maximum of \$750	Monthly Benefit: <input checked="" type="checkbox"/> 60% of salary to a maximum of \$6,000

CRITICAL ILLNESS - Guardian

This benefit is 100% voluntary and paid by you, the employee. Enrollment in this coverage is subject to full carrier guidelines. Completion of this application is not a guarantee of approval for coverage. Please refer to the Guardian Workplace Benefits materials for guarantees, limits, rates and options. Bi-weekly rates for employee and spouse depends on coverage amount elected and employee age bracket.

Employee Critical Illness Benefit Employee coverage must be elected in order to elect coverage for dependents. Available in increments of \$1,000 from \$5,000 to \$50,000.	Spouse Critical Illness Benefit Spouse is eligible for up to 100% of the employee's amount	Child(ren) Critical Illness Benefit Eligible Children are automatically covered for 25% of Amount Elected for Employee at no additional cost
<input type="checkbox"/> I elect \$_____,000 Critical Illness coverage	<input type="checkbox"/> I elect \$_____,000 Spouse Critical Illness coverage	<input type="checkbox"/> I elect 25% of employee's amount
<input type="checkbox"/> I DECLINE Critical Illness coverage for myself and all dependents	<input type="checkbox"/> I DECLINE Spouse Critical Illness coverage	<input type="checkbox"/> I DECLINE Child(ren) Critical Illness coverage

ACCIDENT – Guardian

This benefit is 100% voluntary and paid by you, the employee. If electing, please provide your beneficiary designations in the space below. Enrollment in this coverage is subject to full carrier guidelines. Completion of this application is not a guarantee of approval for coverage. Please refer to the Guardian Workplace Benefits materials for guarantees, limits, rates and options.

Bi-Weekly Deduction & Election:	<input type="checkbox"/> EE only - \$6.92	<input type="checkbox"/> EE/Spouse - \$11.54	<input type="checkbox"/> EE/Child(ren) - \$12.46	<input type="checkbox"/> Family - \$17.07
WAIVE/DECLINE COVERAGE:	<input type="checkbox"/> I DECLINE Accident coverage for myself and all dependents			

ACCIDENT Primary Beneficiary(ies)

Check here if same as Basic Life and AD&D Primary Beneficiary(ies)

Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

ACCIDENT Contingent Beneficiary(ies) In the event the primary beneficiaries are deceased, the contingent beneficiary(ies) will receive the benefit.

Check here if same as Basic Life and AD&D Contingent Beneficiary(ies)

Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #
Full Name	Date of Birth	Relationship to Insured	Benefit %
Home Address			Telephone #

HOSPITAL INDEMNITY INSURANCE – Guardian

This benefit is 100% voluntary and paid by you, the employee. Enrollment in this coverage is subject to full carrier guidelines. Completion of this application is not a guarantee of approval for coverage. Please refer to the Guardian Workplace Benefits materials for guarantees, limits, rates, and options.

Bi-Weekly Deduction & Election:	<input type="checkbox"/> EE Only - \$7.39	<input type="checkbox"/> EE/Spouse - \$13.39	<input type="checkbox"/> EE/Child(ren) - \$11.08	<input type="checkbox"/> Family - \$17.08
WAIVE/DECLINE COVERAGE	<input type="checkbox"/> I DECLINE Hospital Indemnity coverage for myself and all dependents			

ACKNOWLEDGEMENT OF SPECIAL ENROLLMENT RIGHTS

If you are declining coverage for yourself or your spouse or dependent child(ren) because of other health insurance or group health plan coverage, 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 your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have an event of a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, however, you must request enrollment within 30 days after the event. You may also enroll if you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

You as the employee **must** also enroll if you wish to enroll any or all of your dependents in any of the benefit plans offered through Southeast Industrial Equipment or Southeast Handling Systems, which are Subsidiaries of SIE Holdings, Inc.

AUTHORIZATION

Note: Any person who knowingly and with intent to injure, defraud or deceive and who files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony and may result in the denial of claims or cancellation of coverage and may be subject to civil and/or criminal penalties, as well as termination from employment.

I represent that the information I have provided in this enrollment form is complete, true, and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understood the benefit summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

I understand and agree that I must satisfy all active work, active employment and/or active eligibility requirements that pertain to the policy to be eligible for coverage.

I understand that by not applying for the coverages, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for purposes of approval or late penalties may be applied. Penalties such as deferred effective dates or coverages, or pre-existing condition limitations may be imposed on certain benefits as applied by the carriers.

I understand all benefits and rates are subject to modification.

EMPLOYEE NAME: _____
(CLEARLY Print Name)

EMPLOYEE SIGNATURE: _____ **DATE:** _____
(Sign your name, do not print)