WageWorks, Inc.
<P.O. Box>
<City, State, Zip>

Date: 12/18/2017
Form: CLC17
Doc ID: 00000000
Account #: 0000000000

To Sample Participant and Covered Dependents
4609 Regents Boulevard
Irving, TX 75063

Doc: 73347138 Sequence: 3 Form: 55 Server: 1

Client Name: 3-Sample Company, Inc. **Client ID:** 37865
Name: Sample Participant **Account Number:** 000000000

To Sample Participant and Eligible Covered Dependents (if applicable) - 0000000000:

3-Sample Company, Inc. is currently offering open enrollment for plan changes. You may make changes such as choosing different health plan options or adding/deleting coverage for family members for the new plan year, which begins on 01/01/2018.

Enrollments are subject to verification of eligibility on elected health plans and may include rate or plan changes by your plan sponsor. Please use the enclosed form to make any changes to your current coverage and return it to WageWorks.

It is very important that the premium payments for your current coverage are paid through the end of the plan year or you will not be eligible for continuation coverage in the upcoming plan year. **Premium payments must be made even if you do not receive an invoice.** Following your initial premium payment, which is due 45 days after the date of your election, monthly premiums are due on the first day of each month and will be returned if postmarked 30 days after the payment is due. Claims and prescriptions cannot be paid until your payment is received.

Premium payments are considered paid on the date you mail them (*as evidenced by your postmark date*). If your premium payment is made by check, and your check is returned because of insufficient funds, your premium is treated as unpaid. You must make full payment within the required time period, including a grace period, to prevent cancellation. ***If you submit any premium payment after the required postmark date, or if you submit any premium payment and you are otherwise ineligible for coverage, these payments will be refunded to you. Acceptance of premium payments by WageWorks is not an indication that coverage is in force***. *If your coverage is canceled for non-payment of premium, you cannot reinstate it.*

If you have any questions, please contact WageWorks at <Phone Number>.

DEADLINE for CHANGES: If you wish to make changes to your coverage during open enrollment, they must be made within 10 days from the date the notice was mailed. If you do not wish to make any changes, no action is necessary.**
****Please review Section A: Description of Changes to Current Plans to determine whether changes are mandatory.**
ONLINE OPEN ENROLLMENT: You may submit any enrollment changes via the web at mybenefits.wageworks.com which will allow you to then view your new monthly premium. Should you elect online you will not be required to mail in your changes. If you do not wish to make any changes or are not required to, no action is necessary.

RATES: Please note the rates provided on this Open Enrollment form reflect the standard COBRA rates for all participants. If there are any special circumstances that apply to your COBRA continuation coverage such as extended benefits due to disability or severance, your monthly premiums will be reflected on the first invoice for the start of the new rate period. That invoice will reflect the premium that applies to you. You may submit any enrollment changes via the web at mybenefits.wageworks.com which will allow you to then view your new monthly premium.

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Please fill out and return the form on the following pages.
For faster service, fax to <Fax Number> or enroll online at ***<Website>.***

Section A. Description of Changes to Current Plans

Plan Name	Coverage	Description of Changes
BCBSSC HDPPO	Employee Only	The premium for your continuation coverage will be changing as of the new plan year.
Delta Dental	Employee Only	Your current plan is not changing and there is no need to respond unless you wish to change your current coverage.
VSP Vision Plan	Employee Only	The premium for your continuation coverage will be changing as of the new plan year.

Section B.1. Group Health Plan Component(s)

Check the box next to the monthly cost of the group health plan component(s) you are selecting. NOTE: If you are making any changes to your current coverage you **must** select each plan you intend to carry in the new plan year. Please complete Sections C and D to indicate which individual(s) you wish to cover on the plans selected below.

Dental - Delta Dental

Child Only	Employee Only	Spouse Only	Employee + Spouse	Children Only	Employee + Child
☐ $39.38	☐ $39.38	☐ $39.38	☐ $80.77	☐ $84.32	☐ $84.32

Employee + Children	Spouse + Child	Spouse + Children	Family
☐ $84.32	☐ $84.32	☐ $84.32	☐ $139.35

☐ **Check here to Waive Dental Coverage**

Medical - BCBSSC HDPPO

Child Only	Employee Only	Spouse Only	Children Only	Employee + Child	Employee + Children
☐ $417.81	☐ $417.81	☐ $417.81	☐ $751.61	☐ $751.61	☐ $751.61

Spouse + Child	Spouse + Children	Employee + Spouse	Family
☐ $751.61	☐ $751.61	☐ $877.07	☐ $1,253.44

Medical - BCBSSC LDPPO

Child Only	Employee Only	Spouse Only	Children Only	Employee + Child	Employee + Children
☐ $566.44	☐ $566.44	☐ $566.44	☐ $1,019.51	☐ $1,019.51	☐ $1,019.51

Spouse + Child	Spouse + Children	Employee + Spouse	Family
☐ $1,019.51	☐ $1,019.51	☐ $1,189.16	☐ $1,699.15

☐ **Check here to Waive Medical Coverage**

Vision - VSP Vision Plan

Child Only	Employee Only	Spouse Only	Employee + Spouse	Children Only	Employee + Child
☐ $8.24	☐ $8.24	☐ $8.24	☐ $13.19	☐ $13.46	☐ $13.46

Employee + Children	Spouse + Child	Spouse + Children	Family
☐ $13.46	☐ $13.46	☐ $13.46	☐ $21.71

☐ **Check here to Waive Vision Coverage**

Section C. Current Participant Information

Please verify our records are accurate and make changes as necessary. You MUST select the plan type for each individual you intend to cover.

Participant Name	Relationship	Birth Date	Gender
Participant, Sample	Self	11/18/1992	M

☐ Dental ☐ Medical ☐ Vision

☐ **Check Here to Delete Coverage**

Section D. Add Dependents

Check the box next to the dependent you are enrolling on your account. Also select the type of coverage. Each dependent added is subject to eligibility verification prior to receiving coverage. Please note that any dependent(s) added to your coverage may increase your total monthly premium.

Dependent Name	Relationship	Birth Date	SSN	Gender	Tobacco User*
☐ ____________	________	________	________	___	Y / N
Dental ☐ Medical ☐ Vision ☐					

Dependent Name	Relationship	Birth Date	SSN	Gender	Tobacco User*
☐ ____________	________	________	________	___	Y / N
Dental ☐ Medical ☐ Vision ☐					

Dependent Name	Relationship	Birth Date	SSN	Gender	Tobacco User*
☐ ____________	________	________	________	___	Y / N
Dental ☐ Medical ☐ Vision ☐					

Dependent Name	Relationship	Birth Date	SSN	Gender	Tobacco User*
☐ ____________	________	________	________	___	Y / N
Dental ☐ Medical ☐ Vision ☐					

Dependent Name	Relationship	Birth Date	SSN	Gender	Tobacco User*
☐ ____________	________	________	________	___	Y / N
Dental ☐ Medical ☐ Vision ☐					

***See Section B above for any premium information related to any dependents' tobacco use. For more information about tobacco use, please consult your plan sponsor's group health plan materials.**

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Applicant's Authorization and Agreement

By my signature below:

- I elect the coverage checked above in Section B under the 3-Sample Company, Inc. group health plan;
- I verify that all information provided is correct; and
- I understand that if I do not make the appropriate election(s) on this form, I cannot make changes for the upcoming plan year.

Applicant's Signature:______________________________ **Date:**______________

Print Name: ______________________________

If you wish to change your coverage, your response is required.

For faster service, fax to <Fax Number> or enroll online at ***<Website>.*** *Or mail completed form to: WageWorks, Inc. at <P.O. Box, City, State, Zip>.*