



WageWorks, Inc.
 P.O. Box 650407
 Dallas, TX 75265-0407

Date: 11/7/2017
 Form: CLR17-CXDEN
 Doc ID: 72663941
 Account #: 0121280012



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

Doc: 72663941 Sequence: 1 Form: 543 Server: 1

Direct Bill Open Enrollment Notification

To Sample Participant and Eligible Covered Dependents (if applicable) - 0121280012

Sample Company 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. 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.

If you have any questions, please contact our Customer Service Center at 1-877-722-2667.

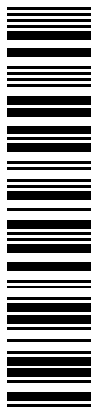
Deadline: This form must be returned to WageWorks within two weeks of the date which it was mailed to you.

Important Note: You cannot change your medical or dental plan, or add dependents, but you may discontinue coverage at any time during the year by contacting the Sample Company Employee Services Call Center at the scsccc@sc.com or the 333-555-9999.

You will be required to send a letter or an e-mail confirming your request to discontinue coverage. If you discontinue coverage, you will not be allowed to reinstate coverage at a later date.

Pursuant to the terms of the Retiree Health Plans, Sample Company, through action by its Board of Directors or a duly authorized Committee or representative, reserves the right to amend or terminate the Plans at any time. You will be notified if this happens; however, the change may be effective before any notice is delivered to you.

00745440000101



Client Name: Sample Company
 Name: Sample Participant

Client ID: 42969
 Account Number: 0121280012

Section A. Description of Changes to Current Plans

<u>Plan Name</u>	<u>Coverage</u>	<u>Description of Changes</u>
DB Delta Traditional Dental Plan RET	Individual + One	The premium for your continuation coverage will be changing as of the new plan year.
DB Indemnity-E Post 65 Group 9	Individual + One	The premium for your continuation coverage will be changing as of the new plan year.

Section B. Plan Alternatives

Place an "X" in the box adjacent to the monthly cost of the coverage(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. Complete Sections C and D to indicate which individual(s) you wish to cover on the plans selected below.

Dental - DB Delta Traditional Dental Plan RET

Individual Only	Individual + One	Individual + Family
<input type="checkbox"/> \$45.00	<input type="checkbox"/> \$90.00	<input type="checkbox"/> \$142.00

Check here to Waive Dental Coverage

Medical w/ Prescription w/ Vision - DB Indemnity-E Post 65 Group 9

Individual Only	Individual + One	Individual + Family
<input type="checkbox"/> \$399.00	<input type="checkbox"/> \$798.00	<input type="checkbox"/> \$998.00

Check here to Waive Medical w/ Prescription w/ 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.

Current Participant Name	Relationship	Birth Date	Gender
Participant, Sample	Self	11/23/1941	M
Dental Insurance	Medical w/ Prescription w/ Vision		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delete Coverage <input type="checkbox"/>

Dependent Name(s)	Relationship	Birth Date	Gender
Participant, Sample Depdt	Spouse	01/21/1951	F
Dental Insurance	Medical w/ Prescription w/ Vision		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delete Coverage <input type="checkbox"/>

Section D. Add Dependents

Please add any additional dependents you intend to enroll on your account and indicate the coverage requested. Each dependent added will be subject to eligibility verification prior to receiving coverage.

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Dental Insurance	Medical w/ Prescription w/ Vision				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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Client Name: Sample Company
Name: Sample Participant

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Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Dental	Insurance	Medical w/ Prescription w/ Vision			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Dental	Insurance	Medical w/ Prescription w/ Vision			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Dental	Insurance	Medical w/ Prescription w/ Vision			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Dental	Insurance	Medical w/ Prescription w/ Vision			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Applicant's Authorization and Agreement

I attest that all information provided is correct. 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: _____

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

For faster service fax to 877-775-9399. Mail completed form to: WageWorks, Inc. P.O. Box 650407 Dallas, TX 75265-0407.