Benefit Confirmation Statement

Correction Deadline
Benefits Effective Date:
Time logged on:

This statement confirms your benefits for the plan year and the dependents covered under your plan. Please review this carefully. If any information is incorrect, you must make corrections using the Internet Enrollment Site before the Correction Deadline, . Refer to your Enrollment Worksheet for instructions.

Keep this Confirmation Statement for your records.

To make changes over the **Internet Enrollment Site** , log on to:	
You will be asked for your **Employee Number** :	_____ (write it here)
and your **Personal ID Number** (PIN):	

Your Benefits	**Election**	**Bi-Weekly Cost**
Total Bi-Weekly Cost:		

Your requested life coverage requires Evidence of Insurability. You must complete and return an Evidence of Insurability (EOI) form. Until your employer receives approval of your EOI from the insurance company, you will receive the coverage amount shown above. Once your employer receives approval, your coverage level and deduction will be adjusted automatically.

Your requested spouse life coverage requires Evidence of Insurability. Your spouse must complete and return an Evidence of Insurability (EOI) form. Until your employer receives approval of the EOI from the insurance company, your spouse will receive the coverage amount shown above. Once your employer receives approval, the coverage level and deduction will be adjusted automatically.

Your requested child life coverage is pending approval of the above Evidence of Insurability (EOI).

Your requested short term disability requires Evidence of Insurability. You must complete and return an Evidence of Insurability (EOI) form. Until your employer receives approval of your EOI from the insurance company, you will receive the coverage amount shown above. Once your employer receives approval, your coverage level and deduction will be adjusted automatically.

Your requested long term disability requires Evidence of Insurability. You must complete and return an Evidence of Insurability (EOI) form. Until your employer receives approval of your EOI from the insurance company, you will receive the coverage amount shown above. Once your employer receives approval, your coverage level and deduction will be adjusted automatically.

Continued on the reverse side

Correction Deadline:

Participants

Listed below are the dependents you selected to be covered under your benefit plan. Review this section carefully. If you find any errors, you may correct them via the Internet Enrollment Site. Follow the instructions on your Enrollment Worksheet.

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Sex	Relationship	Primary Care Physician (PCP)	Elected Coverage

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Sex	Relationship	Primary Care Physician (PCP)	Elected Coverage	

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Sex	Relationship	Primary Care Physician (PCP)	Elected Coverage		

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Sex	Relationship	Primary Care Physician (PCP)	Elected Coverage			

Signature _____ Date _____

Beneficiaries

Listed below are the beneficiaries on file for your life insurance plan. If you need to make changes or corrections, you may do so at any time using the Internet Enrollment Site. If you do not have access to the Internet, please make any additions, deletions, and/or changes below and turn this form in to your Human Resources department.

You can designate both primary and secondary beneficiaries. The percentage allocation for each must add up to 100%.

Beneficiary/Trust Name	Social Security Number	Relationship	Primary or Secondary?	Percentage

Signature _____ Date _____