IPG SERVICES CORP

FLEXIBLE BENEFIT PLAN

Enrollment and Account Election Form – Plan Year: 7/1/08 to 6/30/09

Name _____ SS# _____ - _____ - _____
First Middle Initial Last

Address _____
Street City State Zip Code

Phone: Work ( ) _____ Home ( ) _____

Date of Birth: _____ Age _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced

❑ ***Check box if address has changed from previous year.***

OFFICE USE ONLY

Date of Hire _____
Effective Date _____
PPN # _____
Salary _____
Hrs Worked Per Week _____
Pre-tax ded. _____
After-tax ded. _____

BENEFIT SELECTIONS: Check *Coverage* desired, and enter *Your Weekly Cost* in this column:

1 Employee Life Insurance and Accidental Death & Dismemberment (Lincoln Financial Group)

Choose **Core Benefit *Plus* an Option**

Core Benefit	**Your Cost**
☑ $10,000	**0.00**

Plus

Choose **an Option (if desired)**

❑ $40,000	**2.65**
❑ $65,000	**4.30**
❑ $90,000	**6.00**
❑ $140,000	**9.25**
❑ $190,000	**12.30**

Important: If you are a current plan participant, at each annual enrollment, you may increase your coverage by one level without evidence of insurability. If this is your initial offering for Optional Life insurance with Lincoln Financial Group, you may elect any level of coverage. If you choose **not** to enroll at the initial offering, and wish to enroll at a future annual enrollment, you will be required to provide evidence of insurability and your request for coverage may be denied. ADEA Age reduction is 35% at age 65, 50% of the original amount at age 70. Value of life insurance in excess of $50,000 is taxable income to you.

BENEFICIARY(S): Please name a beneficiary(s) for your Life Insurance and Accidental Death & Dismemberment election:

(First) (Middle Initial) (Last) (Relationship) % (Primary or Secondary)

(First) (Middle Initial) (Last) (Relationship) % (Primary or Secondary)

Multiple beneficiaries will be considered equal unless designated as: Primary (1) or Secondary (2).

Suicide Exclusion: No Supplemental Life benefit will be payable if death results from suicide, whether sane or insane, within 24 months/2 years of the effective date of coverage. Additionally, if death results from suicide, whether sane or insane, within 24 months/2 years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 24 month/2 year period mentioned above will include the period of time coverage was in force under a prior plan

NOTICE: *A PERSON MAY BE COMMITTING INSURANCE FRAUD IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.*

1

Enter YOUR Weekly Cost

$ _____

2 Large Amount Accidental Death & Dismemberment (Lincoln Financial Group) *FOR ACCIDENTS ONLY*

Choose **None *or* an Option**

	Your Cost
❑ **None**	**0.00**

or

Choose **an Option**

Single Coverage		**Family Coverage**	
❑ $100,000 employee only	**1.35**	❑ $100,000 ee, $50,000 spouse, $10,000 children	**1.85**
❑ $150,000 employee only	**2.10**	❑ $150,000 ee, $75,000 spouse, $15,000 children	**2.85**
❑ $200,000 employee only	**2.60**	❑ $200,000 ee, $100,000 spouse, $20,000 children	**3.60**

(This benefit is available for dependent children age 14 days – 19 years (23 years if a full time student) and spouses to age 70.)

2

Enter YOUR Weekly Cost

$ _____

TOTAL FOR PAGE 1: *(Add boxes 1-2)* ⇨ $_____

BENEFIT SELECTIONS: Check *Coverage* desired, and enter *Your Weekly Cost* in this column:

3 Short Term Disability (Guardian)

Choose **None *or* Option**

Your Cost

❑ **None** **0.00**

or

❑ **60% of base weekly income to a maximum of $500.**
Benefits start on the 8th day for an accident or the 8th day for an illness for a maximum of 26 weeks.

1. Insert your Average Weekly Income (Max of $834) _____
2. Multiply by .60 (60%) x .60
3. **YOUR WEEKLY BENEFIT AMOUNT (Max of $500)** _____
4. Multiply by $0.0162 **x 0.0162**
5. Equals the Weekly Cost of Insurance (Insert to Right—Max of $8.10) _____
   (round up to the nearest penny)

⇨

3/3/12 Pre-Existing condition limitation applies. If you are <u>not</u> a current participant and this is <u>not</u> your initial enrollment, you are considered a late enrollee. Late enrollees are required to provide evidence of insurability and requests for coverage can be denied. Late enrollees are responsible for any costs associated with medical evidence of insurability.

3

Enter YOUR Weekly Cost

$_____
(Max of $8.10)

4 Dental Plans (Guardian & First Commonwealth)

Choose **None *or* an Option**

Your Cost

❑ **None** **0.00**

or

Choose **an Option (see description)**

<u>Guardian PPO</u>

100%/75%/50%	❑ Employee Only	**6.35**
$25/$75 Ded Out Net	❑ Employee Plus One	**13.60**
$1,000 Annual Max	❑ Employee Plus Two or More	**22.00**

<u>First Commonwealth DMO</u> **(Please indicate the Provider Location Code in the space below for each family member.)**

$5 Office Visit Copay	❑ Employee Only	**3.35**
100%/80%/50%	❑ Employee Plus One	**6.35**
No deductible	❑ Employee Plus Two or More	**9.75**
$1,000 Ortho Savings		

DMO Provider Location Code (employee) _____ **(spouse)** _____ **(children)** _____

4

Enter YOUR Weekly Cost

$_____

5 Health Plans (Blue Care Network/Blue Cross Blue Shield of Michigan)

Choose **None *or* an Option**

Your Cost

❑ **None** **0.00**
Opt out ONLY with proof of coverage elsewhere. Attach a copy of I.D. card to form.

or

Choose **an Option**

<u>BCN Low Option</u>

$30 Office Visit Copay	❑ Employee Only	**15.76**
$1,000/$2,000 Ded.	❑ Employee Plus One	**78.76**
80%/20% Coinsurance	❑ Employee Plus Two or More	**93.30**
50% ($5 Min, $100 Max) Rx Card, MOPD 2X	❑ Plus Family Continuation per Child (Age 19 –25)	**24.23**

<u>BCN High Option</u>

$20 Office Visit Copay	❑ Employee Only	**44.39**
No Deductible	❑ Employee Plus One	**144.61**
100%/0% Coinsurance	❑ Employee Plus Two or More	**167.74**
$15/$25 Rx Card, 2x MOPD	❑ Plus Family Continuation per Child (Age 19 –25)	**38.55**

<u>BCBSM PPO</u>

$30 Office Visit Copay	❑ Employee Only	**60.19**
$250/$500 Deductible	❑ Employee Plus One	**176.29**
80%/20% Coinsurance	❑ Employee Plus Two or More	**218.09**
$15/$50/50% ($70 Min, $100 Max) Rx Card, MOPD 2X	❑ Plus Family Continuation per Child (Age 19 –25)	**46.44**

5

Enter YOUR Weekly Cost

$_____

TOTAL FOR PAGE 2: *(Add boxes 3-5)* ⇨ $_____

6

Vision Care (Guardian)

***Choose* None *or an* Option**

	Your Cost
❑ **None**	**0.00**

or

***Choose an* Option**

(see description)

❑ Employee Only	**2.50**
❑ Employee Plus One	**5.50**
❑ Employee Plus Two or More	**7.50**

6

Enter YOUR Weekly Cost

$_____

TOTAL FROM PAGE 3: ⇨ $_____

TOTAL FROM PAGE 2: ⇨ $_____

TOTAL FROM PAGE 1: ⇨ $_____

⇨ **Total Weekly Pre-Tax Benefit Cost to You:**
(Add totals from Pages 1, 2 and 3) $_____

Pre-Tax Flexible Spending Account Salary Reduction Options: (Extended Grace Period 7/1/08–9/15/09)

If you choose, you can elect to deposit additional money on a pre-tax basis into either a medical reimbursement account, a dependent care account or both. The money may not be mixed between the two accounts. The choice can only be made once each plan year and cannot be changed except in the event of a qualified status change. For details regarding specific status changes, please see your Summary Plan Description. At the end of the grace period, any money not used must, by law, be forfeited.

I elect to reduce my weekly wages and put the money into the following accounts:

❑ **Medical Reimbursement Account**

$ _____ per weekly pay period, Minimum amount is $5.00; Maximum amount is $38.46 based on a full plan year ($2,000 per year)

❑ **Dependent Care Reimbursement Account***

$ _____ per weekly pay period, Minimum amount is $5.00; Maximum amount is $96.15 based on a full plan year ($5,000 per year)

****You must also complete the Dependent Care Assistance Plan Authorization Form in order to participate in a dependent care reimbursement account.***

Dependent Life Insurance (Lincoln Financial Group)

***Choose* None *or* an Option**

This benefit is available for dependent children 14 days – 19 years (23 years if a full-time student) and spouses to age 70. This benefit is not part of the Flexible Benefit Plan. Amounts below are after tax.

	Your Cost
❑ **None**	**0.00**

or

***Choose an* Option**

❑ $5,000 on spouse and $2,000 on children	**0.45**
❑ $10,000 on spouse and $4,000 on children	**1.00**
❑ $15,000 on spouse and $6,000 on children	**1.75**
❑ $20,000 on spouse and $8,000 on children	**2.50**

Enter YOUR Weekly After-Tax Cost

$_____

Important: If you were offered dependent life coverage previously, you may elect any dependent life option up to the guarantee issue of $15,000 without evidence of insurability. **For coverage options above the guarantee issue, you may only increase coverage by one level each year without providing evidence of insurability.** If this is your initial offering for Dependent Life insurance with Lincoln Financial Group, you may elect coverage up to the maximum level. If your spouse or dependent child is confined in a hospital or elsewhere because of a disability on the date insurance would normally become effective, coverage (or an increase in coverage) will be denied until that dependent is no longer confined and has performed all of the normal activities of a healthy person of the same age for at least 15 consecutive days.

Enrollment/Coordination of Benefits Information:

List those individuals to be covered under the Vision, Dental or Health Plans.
NOTE: You may only cover legally married spouses, and children to age 19 or to age 25 if full-time student.

	LAST NAME	FIRST	M.I.	SEX	SS#	BIRTHDATE	AGE	FT STUDENT?	VISION	DENTAL	HEALTH
EMPLOYEE											
SPOUSE											
CHILD											
CHILD											
CHILD											
CHILD											
CHILD											
CHILD											

Are you covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

Is your spouse covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

Are your children covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

If you answered Yes to any of the above questions, please complete the following:

Insured's Name_____ Social Security #_____ Date of Birth_____

Name of other Insurance Company or Third Party Administrator:_____ Group # _____

Employer providing other coverage:_____

Benefits provided by other coverage:_____

NOTE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you wish to add a new dependent or terminate coverage as a result of a change in family status, such as marriage, birth, adoption, or placement for adoption, you may be able to do so, provided that you request enrollment/termination within 30 days after the qualified status change.

IMPORTANT!

If any dependent listed above is covered under the Health, Dental or Vision plan, and does not reside at the address shown on Page 1 of this form, please provide their current address below:

Name **Current Address**

_____

Signature/Authorization

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that my employer has signed with the insurance carriers and plan documents will be binding. I understand that this election may not be changed during the plan year unless I have a qualified status change and that unused allocations, if any, by law, will be forfeited according to the plan documents. I understand that my coverage becomes effective on the first day of the month following 30 days of employment, and ends on the last day of the month in which my employment terminates. I authorize my employer to reduce my wages by the amounts required (if needed) to pay for the Flexible Benefit Options I have elected. My signature below acknowledges my elections on pages 1, 2 and 3.

Signature_____ Date_____