

Benefits Enrollment/Change Form for Executives/Clinicians

Plan Year: January 1 - December 31, 2012

Fax or scan/email this Form to the Concentra Benefits Call Center. Keep original for your records, including confirmation details.

Fax No.: (866) 724-1843

Tel No.: (888) 875-0453

Email: benefits@concentra.com

<input type="checkbox"/>	New Hire/Newly Eligible		
<input type="checkbox"/>	Qualified Status Change Reason: _____	Effective Date: _____	

This Form must be completed in full, signed, and faxed or scanned and emailed to the Concentra Benefits Call Center within 31 days from (1) the date of hire/eligibility, or (2) the date of qualified status change. Please refer to the **2012 Benefits Guide** for benefit plan details (i.e. eligibility, coverage specifics, premium rates). Blank sections will be assumed not applicable or constitute a decline in benefit coverage. Your elections will remain in effect for the entire 2012 Benefit Plan Year and changes will **NOT** be permitted unless you experience a Qualified Status Change and submit a new **Benefit Enrollment/Change Form** to the Benefits Call Center within 31 days from the date of your status change. Eligibility and Qualified Status Change rules are provided in the 2012 Benefits Guide. For assistance, please contact the Concentra Benefits Call Center at 1-888-875-0453 or at benefits@concentra.com.

1. COLLEAGUE INFORMATION *(Please print legibly)*

Last Name		First	M.I.	First 5 Digits of SSN, or Colleague ID#		
Home Address		Apt #	City		State	Zip Code
Marital Status	Gender	Home/Work Phone		Cell Phone	Email Address	
Hire/Status Change Date		Job Title		Job Location (City, ST, Zip Code)		

2. DEPENDENT INFORMATION

Complete this section for each eligible dependent you are enrolling in the Medical, Dental, Vision, Optional Dependent Life & AD&D plans. If your Spouse/Domestic Partner is eligible under his/her own employer's medical and or dental plans, he/she is NOT eligible for coverage under Concentra's medical and/or dental plans.

Relationship Codes (R.C.): **SP**/spouse, **DP**/domestic partner, **CH**/dependent child/ren under age 26, **LG**/legal guardian

You must provide the SSN and Date of Birth for eligible dependents (age 6 mo. & older) and all information for other dependents.

R.C.	First Name	MI	Last Name	SSN	Date of Birth	Gender M/F

3. MEDICAL PLAN **4. Dental Plan**

<input type="checkbox"/> Humana CDHP/OOA <input type="checkbox"/> UPMC PPO Pittsburgh <input type="checkbox"/> UPMC HMO Pittsburgh <input type="checkbox"/> I decline Medical Coverage	<input type="checkbox"/> Colleague Only <input type="checkbox"/> Colleague + Spouse/DP <input type="checkbox"/> Colleague + Child/ren <input type="checkbox"/> Colleague + Family
<input type="checkbox"/> Humana Traditional Plus <input type="checkbox"/> I decline Dental Coverage	<input type="checkbox"/> Colleague Only <input type="checkbox"/> Colleague + Spouse/DP <input type="checkbox"/> Colleague + Child/ren <input type="checkbox"/> Colleague + Family

5. SHORT TERM DISABILITY **6. LONG TERM DISABILITY PLUS** *(Basic LTD paid by Concentra)*

<input type="checkbox"/> I elect Short Term Disability <input type="checkbox"/> I decline Short Term Disability Coverage	<input type="checkbox"/> I elect Long Term Disability PLUS <input type="checkbox"/> I decline Long Term Disability PLUS Coverage
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7. VISION CARE PLAN **8. CRITICAL ILLNESS** *(Medical Coverage Required-Any Carrier)*

<input type="checkbox"/> EyeMed Vision Care Plan <input type="checkbox"/> I decline Vision Coverage	<input type="checkbox"/> Colleague Only <input type="checkbox"/> Colleague + Spouse/DP <input type="checkbox"/> Colleague + Child/ren <input type="checkbox"/> Colleague + Family
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To enroll in the Critical Illness Insurance, print a **MetLife Critical Illness Application** and mail or fax to MetLife within 31 days following the date of your eligibility. For a MetLife Representative, call (800) 438-6388.
The Application can be found under the 2012 Plan Year Forms section on www.ConcentraTotalBenefits.com
(Login: colleague; Password: concentra)

9. FLEXIBLE SPENDING ACCOUNTS Please visit www.ConcentraTotalBenefits.com (Login: colleague, Password: concentra) (Forms/Benefit Forms) to print a Debit Card Authorization form and fax the completed form with your enrollment form.

**For Health/Dependent Care, contribution maximum is \$5,000 annually.
For Commuter Benefit, contribution maximum is \$120.00 per pay period.**

<input type="checkbox"/> \$ <input style="width: 80px;" type="text"/> for Health Care	<input type="checkbox"/> I decline Health Care FSA
<input type="checkbox"/> \$ <input style="width: 80px;" type="text"/> for Dependent Care	<input type="checkbox"/> I decline Dependent Care FSA
<input type="checkbox"/> \$ <input style="width: 80px;" type="text"/> for Commuter Benefits	<input type="checkbox"/> I decline Commuter Benefits

10. OPTIONAL GVUL – EXECUTIVE/CLINICIAN
(Basic Life – Colleague paid by Concentra)

11. OPTIONAL GVUL - DEPENDENT
(Spouse, Domestic Partner, and unmarried dependent child up to age 26)

To enroll or change your Optional GVUL elections or receive premium quotes, please visit MetLife.com, call 1.800.846.0124 or refer to your MetLife enrollment/change packet for complete instructions.

I decline Optional Life – Colleague

To enroll or change your Optional GVUL elections or receive premium quotes, please visit MetLife.com, call 1.800.846.0124 or refer to your MetLife enrollment/change packet for complete instructions.

I decline Optional Child Life **I decline** Optional SP/DP Life

12. OPTIONAL AD & D (Basic AD&D paid by Concentra)

13. HYATT LEGAL PLAN

Elections must be stated in \$25,000 increments up to \$350,000; Amounts over \$250,000 cannot exceed 10 X annual base salary.

I elect to purchase the following Optional AD&D Coverage:

Colleague Only **OR** Colleague Plus Family

Coverage Amount: \$

I elect the Hyatt Legal Plan from MetLaw

I decline the Hyatt Legal Plan from MetLaw

14. A.C.T.S. (ACTION * COMPASSION * TEAMWORK * SUPPORT)

15. AUTO INSURANCE

\$ Enter Contribution Amount

I decline ACTS contributions

Contact MetLife at (800) Get-Met8 or (800) 438-6388
You may add/drop coverage any time throughout the year.

16. HOME INSURANCE

17. VETERINARY PET INSURANCE

Contact MetLife at (800) Get-Met8 or (800) 438-6388
You may add/drop coverage any time throughout the year.

Contact MetLife at (800) Get-Met8 or (800) 438-6388
You may add/drop coverage any time throughout the year.

18. CERTIFICATION AND AUTHORIZATION FOR PAYROLL DEDUCTED PREMIUM PAYMENTS

I certify that the information provided on this Form is true and correct to the best of my knowledge. I understand that intentionally providing false information may constitute fraud, subject to disciplinary procedures including termination. I certify that the dependents listed are my eligible dependents as defined by Concentra's Dependent Eligibility Rules and the Plan Documents. I also understand that my enrolled dependent(s) are subject to audit, and that I may be required to supply supporting documentation to verify her/his eligibility. If she/he is found to be ineligible, I may be responsible for any claims incurred or paid during the ineligibility period. I acknowledge receipt of the **2012 Benefits Guide**. I agree to abide by the provisions set forth in the Benefit Plan Documents, and I authorize premium payments for my elections to be deducted from my paycheck as indicated by my signature.

EXECUTIVE/CLINICIAN SIGNATURE
This Form must be signed and dated to be valid.

_____	_____	_____
Executive/Clinician's Signature	Print Name	Date

BENEFICIARY DESIGNATION FORM

Last Name	First	M.I.	First 5 Digits of SSN, or Colleague ID#
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Beneficiary Designations apply to Basic Life, Basic & Optional AD&D, and Business Travel Accident, if applicable. Please clearly list your primary and secondary beneficiary designation(s), providing the requested information below.

The Beneficiary Designation for Life/GVUL/AD&D/Business Travel Insurance coverage(s) will be changed upon written request.

For Optional GVUL – Dependent (spouse, domestic partner and child/ren) policies, the beneficiary is automatically you, if surviving, otherwise the estate of the spouse, domestic partner, and child/ren becomes the beneficiary, subject to policy provisions.

PRIMARY BENEFICIARY

Full Name of Person	Address	Relationship to You		
	Street			
Date of Birth	City	State	Zip	Share %
	Street			
Date of Birth	City	State	Zip	Share %
	Street			
Date of Birth	City	State	Zip	Share %
	Street			
Date of Birth	City	State	Zip	Share %

Attach a separate beneficiary designation page, if necessary.

Total shares must equal 100%

SECONDARY BENEFICIARY

Full Legal Name	Address	Relationship to You		
	Street			
Date of Birth	City	State	Zip	Share %
	Street			
Date of Birth	City	State	Zip	Share %
	Street			
Date of Birth	City	State	Zip	Share %

Attach a separate beneficiary designation page, if necessary.

Total shares must equal 100%

EXECUTIVE/CLINICIAN SIGNATURE

This Form must be signed and dated to be valid.

Executive/Clinician's Signature	Print Name	Date
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