

OTHER COVERAGE INFORMATION

Do you or any dependents applying for coverage have other group medical or dental insurance in effect now that will not terminate upon this plan's effective coverage? Yes No

If yes, please answer the following questions:

Type of Insurance: Group Individual Medicare Medicaid Other

Effective date of other coverage: _____ Other coverage includes: Medical Dental

Name of Policyholder: _____ Policy #: _____

Name of other Insurance Company: _____

Address: _____ City, ST, Zip : _____

Phone Number: _____

Identify each person insured: _____

Have you or any dependents applying for coverage been covered under this employer's group medical plan or had other health insurance coverage in the past 12 months. Yes No

I hereby acknowledge my receipt of the Notice of Privacy Practices.

I certify that I have selected the above plan option(s) and that I fully understand the terms and conditions of the plan(s). I further certify that the above listed information is true and correct. If I knowingly elect coverage for ineligible dependents, I understand and agree the Health Plan may seek to recover all paid claims. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance. I understand if my employment is terminated, upon re-employment, insurance will not be effective until I again apply for insurance in accordance with the terms of the group policy.

I agree on behalf of myself and those family members enrolled ("Dependents") for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that BMI and their authorized representatives may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering health insurance benefits, including for treatment, payment or health care operations, as those terms are explained in detail in the Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness and substance abuse to the Health Plan for the Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I understand that if I choose to decline coverage, I waive the right to the Health Plan's coverage until the next open enrollment, unless my dependents or I experience a Special Enrollment qualifying event.

Employee Signature

Date

Print Name

LIFE INSURANCE INFORMATION

Becker Tire and Treading, Inc. provides to all full-time employees \$15,000 life coverage at no cost to the employee. Please list your beneficiary information below. Contingent Beneficiary(ies) should be named in the event that the Primary Beneficiary(ies) pre-deceases the Covered Employee.

LIFE INSURANCE BENEFICIARY INFORMATION

Name your Primary Beneficiary(ies)

Name	Address	Social Security #	Date of Birth	Relationship	%
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Name your Contingent Beneficiary(ies)

Name	Address	Social Security #	Date of Birth	Relationship	%
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Employee Signature

Date

Print Name