CNIC
★ FLEET ★ FIGHTER ★ FAMILY

Name: _____ **Sex:** ❑ Female ❑ Male
LAST FIRST MI

Date of Birth: ____/____/____ **Social Security #:** ____-____-____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Activity Name: _____ **Location:** _____

INSTRUCTIONS

You can use this form to enroll in and change your coverage for Medical, Dental, Disability, Life Insurance, Flexible Spending Account, and Retirement. Check the boxes that apply to you and fill in the appropriate parts of this form. Sign the form and keep your copy. Return the originals to Human Resources or Benefits representative.

❑ **This is a new enrollment**
- ❑ New Hire
- ❑ Change in Status
- ❑ Reinstatement
- ❑ Open Enrollment

❑ **I am changing a coverage election** (Complete Part 1)

❑ **I am waiving or cancelling coverage** (Complete Part 2)

PART 1: COVERAGE ELECTION

Check the boxes below to indicate which coverage you want. You must fill out an enrollment and beneficiary form for each benefit. If you are enrolling for Medical or Life insurances, also indicate the level of coverage you want.

❑ **I want to enroll in the Medical Plan** (check one):
- ❑ POS II
- ❑ HMO
- ❑ Other

❑ **I want to enroll in** (check one):
- ❑ Dental
- ❑ Stand Alone Dental

❑ **I want to cover** (check one):
- ❑ Employee Only
- ❑ Employee + 1
- ❑ Employee + Child(ren)
- ❑ Employee + Spouse
- ❑ Employee + Family

❑ **I want to enroll in the Life Insurance Plan** (check all that apply):
- ❑ Basic Life (1 times pay +$2000)
- ❑ Optional Life (1-6 times salary) _____ times
- ❑ Dependent (Child) Life: ❑ $5,000 ❑ $10,000
- ❑ Spouse Life: ❑ $10,000 ❑ $25,000 ❑ $50,000

❑ **I want to enroll in the Disability Plan**

❑ **I want to enroll in the Flexible Spending Plan**

❑ **I want to enroll in the Retirement Plan**

❑ **I want to enroll in the 401 K Plan**
(*Must self-enroll online at www.wellsfargo.com or call 800-728-3123*)

PART 2: WAIVE/CANCEL

Check the boxes below that apply to you. I have received information about the CNIC benefits available to me and I decline coverage at this time. I also understand that there are restrictions in joining the plan at a later date. The benefits booklets explain the late enrollment procedures. **I want to:** ❑ **waive** ❑ **cancel** (check all that apply)

- ❑ POS II
- ❑ HMO
- ❑ Basic Life
- ❑ Dental
- ❑ Stand Alone Dental
- ❑ Optional Life
- ❑ Flexible Spending Account
- ❑ Long Term Disability
- ❑ Spouse Life
- ❑ Retirement
- ❑ 401 K
- ❑ Dependent (Child) Life

I understand and accept the terms of the Medical, Life, Disability, Flexible Spending Account, and Retirement plans as they affect the elections I have made on this form.

EMPLOYEE'S SIGNATURE _____ **DATE** _____ **EFFECTIVE DATE OF COVERAGE** _____

HR REPRESENTATIVE'S SIGNATURE _____ **DATE** _____