CASCADE DESIGNS°

EMPLOYEE BENEFIT ENROLLMENT/CHANGE FORM

January 1 – December 31, 2022 Plan Year

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SECTION D: If declining medical plan coverage, please complete this section												
	u or your dependents have coverage under an			ge)? 🗌 NO 🔄 YES - If y	es, please complete the	information below						
Name	e and address of insurer:			Identification	Policy #							
Name	Name of policy holder: Date coverage began:											
Family members covered (list all):												
Type of Coverage (check all that apply):												
SECTION E: Current/prior coverage information												
Please indicate for each person listed on this application any health insurance (including Medicare and Medicaid) in effect within the 24 month period prior to the proposed effective date of coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate none. If you are covered under another medical or dental benefit policy and this coverage will continue, your benefits through Cascade Designs are considered your primary benefits and your other benefit coverage is secondary.												
	Applicant's Name	Insurance carrier, Policy Number and Phone Number	Date of Coverage Will coverage From and To continue?		Type of Coverage	Type of Product						
			FIOIII dilu 10		Group							
				Yes / No	Individual	Dental						
				Yes / No	Group	Medical Dental						
				Yes / No	Group	Medical Dental						
				Yes / No	☐ Group ☐ Individual	Medical Dental						
SECTION F: Employer paid Life/AD&D beneficiary information												
This beneficiary designation applies to your employer paid Life/AD&D only. If you are enrolled in the optional Life/AD&D please also complete the Prudential beneficiary section in the Mutual of Omaha Optional Life/AD&D enrollment paperwork.												
PRIMARY Beneficiary Designation (If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.)												
	Name	SSN	Relationship	Street address, cit	y, state, zip code	%						
1.			I	· · ·	<u>, </u>							
2.												
3.												
CONTINGENT Beneficiary Designation (Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive)												
Name		SSN	Relationship	Street address, cit		%						
1.												
2.												
3.												
L	I	I										

Release & Authorization

I hereby apply for coverage under the contracts between the administrators and insurance carriers (RGA and Mutual of Omaha) and my employer, and I agree with the terms of the contracts. I also apply for the same coverage for my spouse/domestic partner and/or my dependent children listed on this application. I certify that my listed dependents and I meet all the eligibility criteria set forth in the benefit guide, dependent eligibility verification form, plan documents and/or contract. I further understand that it is my obligation to notify Human Resources when my spouse, domestic partner or child no longer meets the eligibility requirements described under the Plan. Once a person does not meet the Plan definition of a spouse, domestic partner or dependent child (e.g. due to divorce) they are no longer eligible for benefits. I understand that false or inaccurate information (including misrepresentation of dependent status) and failure to notify my employer that my dependent(s) no longer meet the dependent definition may result in the termination of coverage, non-payment of benefits, recovery of ineligible benefit payments from me or my healthcare providers, termination of employment and/or legal action. I authorize the payroll deductions for health insurance coverage noted in Section C.

Employee Signature