



Enrollment Form



INSTRUCTIONS

Please complete and return this Enrollment Form to the Human Resources Department (by either fax or U.S. Mail) within 31 days of your employment date.

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Employee Information:

Last Name	First Name	MI	Social Security Number
Street Address	City	State	Zip
Home Phone Number	Birth Date (Mo/Day/Year)	Work Site	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	Hire Date (Mo/Day/Year)	Occupation or Position	

Family Information (Medical and Dental):

If you are enrolling your eligible dependents you must complete the following information.

NAME	Disabled?	F/T Student?	Sex M/F	Social Security Number	Birth Date (Mo/Day/Yr)
SPOUSE / DOMESTIC PARTNER NAME					
CHILD NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
CHILD NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
CHILD NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
CHILD NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
CHILD NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

If you have more than five dependent children, please complete an additional enrollment form. Request for proof of full-time student status is required for children between the ages of 19 and 25 at the time claim is submitted.

Spousal / Same-Sex Domestic Partner Affidavit

- 1) Does your spouse/domestic partner have other medical coverage available to them (excluding Medicare)? Yes No
- 2) If **No**, no further response is required in this section.
- 3) If **Yes**, are you choosing to cover your spouse/domestic partner on Pediatrix's medical plan in 2007? Yes No

Please note: Employees whose spouse/domestic partner has the ability to obtain coverage elsewhere but would still like to be enrolled in the Pediatrix medical plan, an additional \$100 per month charge will be added to your monthly premium. This charge will be cancelled if you later remove your spouse from Pediatrix's medical plan.

Medical Plan: Please select one of the following options

Core PPO

- Employee Only
- Employee Plus Spouse/Domestic Partner
- Employee Plus Child(ren)
- Employee, Spouse/Domestic Partner, Child(ren)

Enhanced PPO

- Employee Only
- Employee Plus Spouse/Domestic Partner
- Employee Plus Child(ren)
- Employee, Spouse/Domestic Partner, Child(ren)

Waive Coverage

I understand that if I elect to waive coverage now I will not be permitted to enroll in a medical plan until the next enrollment period (unless I have a qualified family status change).

Medical Benefit Credit

I understand I must provide proof of coverage to qualify for the benefit credit.

Dental Plan: Please select one of the following options

- Employee Only
- Employee Plus Spouse/Domestic Partner
- Employee Plus Child(ren)
- Employee, Spouse/Domestic Partner, Child(ren)

Waive Coverage

I understand that if I elect to waive coverage now I will not be permitted to enroll in a dental plan until the next enrollment period (unless I have a qualified family status change).

Dental Benefit Credit

I elect to waive dental coverage and wish to receive a benefit credit.

Reimbursement Accounts:

Health Care Reimbursement Account

Calendar Year Election Amount: _____
(cannot exceed \$5,000)

Dependent Care Reimbursement Account
(Availability subject to IRS participation requirements)

Calendar Year Election Amount: _____
(cannot exceed \$5,000)

Basic Life, AD&D, Long-Term Disability, and Employee Assistance Program:

Pediatrix Medical Group automatically provides eligible employees with Basic Term Life and AD&D, Long-Term Disability Insurance and the Employee Assistance Program at *no cost to you*.

Information About Your Beneficiary(ies):

Always complete this section of the form for Basic Term Life and AD&D Insurance even if you are not enrolling for any other coverage through the Pediatrix Medical Group Employee Benefits Program. Please indicate the percentage of benefit to be paid if you are listing more than one beneficiary. If you need additional space, please attach a separate sheet. **If you elect to purchase Supplemental Term Life Insurance, these beneficiary(ies) would apply.**

Primary Beneficiary Name	Address	Relationship to You	Benefit %
Primary Beneficiary Name	Address	Relationship to You	Benefit %
Secondary Beneficiary Name	Address	Relationship to You	Benefit %

Optional Term Life & Short-Term Disability:

Short-term Disability:

- I elect to enroll in Short-term Disability coverage
- I decline Short-term Disability coverage

I understand that if I wish to enroll in short-term disability or Optional life insurance at a later date, I will be required to furnish evidence of insurability at my own expense and the carrier may refuse my request.

Dependent Term Life: (Employee must participate in optional Term Life to elect spouse/child coverage)

- _____ Spouse Benefit
(\$10,000 increments not to exceed 50% of employee optional life benefit)
- _____ Child Benefit
(\$5,000 increments not to exceed 50% of employee optional life benefit)
- I Decline Spouse Life Insurance
- I Decline Child Life Insurance

Optional Term Life:

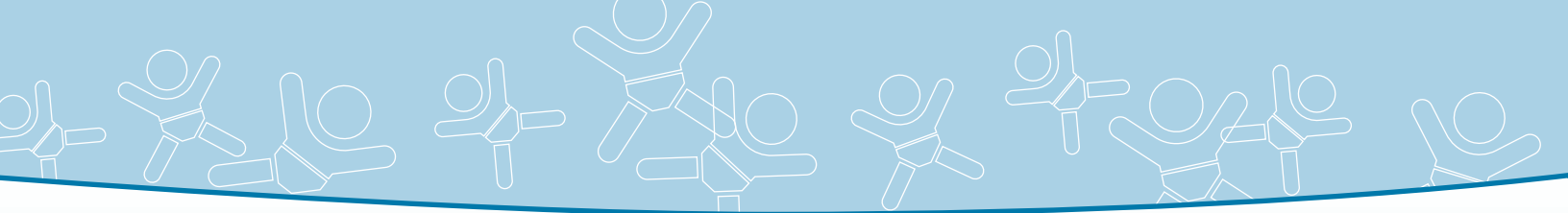
- I Decline Optional Term Life Insurance
- Coverage Amount Selected: _____

Please note: Coverage amounts must be in an increment of \$10,000 not to exceed the lesser of five times your annual salary or \$750,000. Any amount you elect exceeding the lesser of two times your base annual earnings or \$300,000 requires medical evidence of insurability and approval of the insurance carrier.

Employee Authorization

*I certify that the above information represents my enrollment choices for the 2007 plan year. I understand that by signing this form I am electing to reduce compensation in exchange for pre-tax medical and dental coverage (if employee contributions are required) and participation in the flexible spending accounts or other voluntary benefits that require a contribution. I further understand my coverage elections cannot change until a future open enrollment period or a qualified family status change occurs. I understand that I must notify Human Resources within 31 days of a family status change to change my 2007 plan elections. I represent to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. **I understand falsification of any information on this form may be grounds for immediate termination from employment.** I understand and agree to the terms and conditions described above.*

Employee's Signature: _____ **Date:** _____



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