

**GROUP NO.  
352150**



**CHANGE  
WORKSHEET**

**Please Read & Follow "WHEN TO USE THIS CHANGE WORKSHEET" (on the back) BEFORE making the call.**

- After filling in all your information, call the SRC Benefits Line at **1-800-977-6974**. A voice will prompt you through your enrollment entries.
- Select the option "To make your benefit elections" .....press:
- Enter your access code .....
- Enter your Social Security Number .....(please fill in):    -   -
- To make your Benefit Elections .....press:
- To *add or increase coverage*, enter your QLE Code provided by your Benefits Department (see reverse) .....:    
**OR**  
 To *drop or reduce coverage levels* enter .....:
- Find the **Coverage Code** from the chart below that matches the level of coverage you are requesting for each benefit. Fill in the corresponding blank keys with the **Coverage Code** you choose for each benefit. During your call, you will be asked to enter the **Coverage Codes** for those benefits you wish to change. *You do not need to enter Coverage Codes for those benefits you are not changing.*

	Coverage Code	Level of Coverage	Weekly Premium Amount		
	0	.No Medical	.NONE	For <b>Medical</b> Press: <input type="text" value="1"/>	Choose the level of coverage you wish to change to. Enter that Coverage Code here: <input type="text"/> <i>List Dependent Information on the back.</i>
	1	.Yourself Only	.\$15.86		
	2	.Yourself & Family	.\$46.86		
	0	.No Dental	.NONE	For <b>Dental</b> Press: <input type="text" value="2"/>	Choose the level of coverage you wish to change to. Enter that Coverage Code here: <input type="text"/> <i>List Dependent Information on the back.</i>
	1	.Yourself Only	.\$ 4.45		
	2	.Yourself & Family	.\$12.75		
	0	.No Term Life	.NONE	For <b>Term Life</b> Press: <input type="text" value="3"/>	Choose the level of coverage you wish to change to. Enter that Coverage Code here: <input type="text"/> <i>List Dependent &amp; Beneficiary Info. on the back.</i>
	1	.Yourself Only	.\$ 1.54		
	2	.Yourself & Family	.\$ 1.88		
	0	.No Short Term Disability (STD)	.NONE	For <b>STD</b> Press: <input type="text" value="4"/>	Choose the level of coverage you wish to change to. Enter that Coverage Code here: <input type="text"/>
	1	.Yourself Only <sup>1</sup> <sup>2</sup>	.\$ 3.50		
		<sup>1</sup> Not available in California, Hawaii, New Jersey, New York, Rhode Island, & Puerto Rico. <sup>2</sup> The cost doubles at age 65.			

- Write down your **Confirmation Number**: \_\_\_\_\_ (Given to you during the call.)  
*If you do not hear your Confirmation Number, your benefit elections may not have been accepted.*
- If you elected dependent coverage for any of the benefits listed above, you will be transferred to a Customer Service Representative who will ask you for the **Dependent Information** you filled out on the back of this worksheet.
- After completing your call, sign your name and date the **Authorization** section on the back of this worksheet.
- Make a copy of this worksheet. Keep the copy with your Summary Plan Description you will receive in the mail.
- Mail your original, signed worksheet to: Benefits Department  
 1040 Crown Pointe Parkway, Suite 1040  
 Atlanta, GA 30338

**PLEASE ENTER AUTHORIZATION, DEPENDENT, AND BENEFICIARY INFORMATION ON REVERSE ►**

## WHEN TO USE THIS CHANGE WORKSHEET

This worksheet allows you to:

- Change enrollments, including dropping coverage (your employer's Plan may have certain requirements that affect your ability to drop coverage).
- Change information about yourself, your dependents, or your beneficiary.

### BENEFIT CHANGES BETWEEN OPEN ENROLLMENT PERIODS - QUALIFYING LIFE EVENTS (QLE)

If you are currently enrolled, you may be allowed to *add, change, or drop* enrollment when you experience certain events.

- **To drop coverage or reduce coverage** (e.g., "You & Family" to "Yourself Only"), enter "99" as the QLE Code in line #6 on the front of this worksheet and follow the instructions.
- **To add coverage or increase your coverage** (e.g., "Yourself Only" to "You & Family"), you must check the box below that describes your Qualifying Life Event, **then call your corporate Benefits Department at 1-800-605-8304 within 31 days of the event** to request your QLE Code. You may be required to submit documentation of the Qualifying Life Event to your Benefits Department.

Write your QLE Code, as given to you by your Benefits Department, here: \_\_\_\_\_

Then, in line #6 on the front of this worksheet, enter the QLE Code you have written above.

Qualifying Life Events Resulting In A Loss Of Other Coverage	Family Status Changes
<input type="checkbox"/> Divorce, legal separation, or death <input type="checkbox"/> Termination of employment of a dependent <input type="checkbox"/> Reduction of a dependent's work hours <input type="checkbox"/> Termination of your or your dependents' COBRA rights <input type="checkbox"/> Loss of employer's contribution to spouse's coverage <input type="checkbox"/> Other loss of coverage	<input type="checkbox"/> Divorce, legal separation, or death <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or adoption of a dependent <input type="checkbox"/> Other

### AUTHORIZATION

**YES.** I have read the attached plan overview and limitations and exclusions. I understand the terms of the insurance coverage in which I am enrolling. By using the telephone enrollment system, I AUTHORIZE my employer to make payroll deductions for the insurance coverage in which I am enrolling and release other necessary information to the administrators of this plan.

SIGNATURE \_\_\_\_\_

DATE (MM/DD/YY) \_\_\_\_\_

### DEPENDENT INFORMATION

Your eligible dependents are your lawful spouse and unmarried dependent children under 25 years of age. Dependent age and status requirements may vary by state.

NAME (First, Middle Initial, Last)	RELATIONSHIP
SOCIAL SECURITY NUMBER - - / /	ENROLLED IN <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> TERM LIFE
NAME (First, Middle Initial, Last)	RELATIONSHIP
SOCIAL SECURITY NUMBER - - / /	ENROLLED IN <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> TERM LIFE
NAME (First, Middle Initial, Last)	RELATIONSHIP
SOCIAL SECURITY NUMBER - - / /	ENROLLED IN <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> TERM LIFE

IF ANY OF YOUR DEPENDENTS LIVE AT AN ADDRESS OTHER THAN YOURS, INDICATE THEIR NAME AND ADDRESS BELOW OR ATTACH A SEPARATE SHEET.

NAME (First, Middle Initial, Last)	CITY	STATE	ZIP CODE
STREET ADDRESS			

### BENEFICIARY INFORMATION

PRIMARY BENEFICIARY'S NAME (First, Middle Initial, Last)      RELATIONSHIP      SOCIAL SECURITY NUMBER

#### ¿HABLA ESPAÑOL?

Si usted tiene dificultad en entender cualquier parte de este formulario llame al número gratuito 1-800-977-6974. Nuestros representantes de consulta están disponibles de 8:00 a.m. a 8:00 p.m., de lunes a viernes (hora del Este) para darle asistencia en español.

**If you have questions...Call 1-800-977-6974**  
**Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.**

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Record keeping by Strategic Resource Company, Columbia, South Carolina;  
SRC Insurance Services, Inc.; SRC Services, Inc



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