KENAI DRILLING LIMITED ENROLLMENT/CHANGE FORM

SECTION I: HR USE ONLY

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE

QUALIFYING EVENT DATE: _______________ EFFECTIVE DATE: _______________ HIRE DATE: _______________ LOCATION: _________________

EMPLOYEE TYPE: ☐ Full-time ☐ Part-Time ☐ Variable/Temp/Seasonal TYPE OF CHANGE: ☐ Add dependent(s) ☐ Demographics

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

MEDICAL OPTIONS:

☐ **IN EPO**

☐ **PPO**

☐ **HDHP-HSA**

DENTAL/VISION OPTION:

☐ **AMERITAS**

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE
STREET ADDRESS		CITY	STATE	ZIP
PHONE	E-MAIL ADDRESS		☐ Single ☐ Married ______/______/______ ☐ Separated ☐ Divorced ☐ Widowed	

ENROLLED IN OTHER HEALTH INSURANCE UNDER A GROUP PLAN OR MEDICARE? ☐ YES ☐ NO If yes, please provide the following:

Effective Date of Coverage: ________________

Insurance Carrier: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Other _________________________________

IF YOU ARE WAIVING/DECLINING COVERAGE PLEASE CHECK ALL BOXES THAT APPLY: ☐ Waive Medical ☐ Waive Dental/Vision

Reason for Declining Medical: ☐ I have coverage under another group plan (e.g. spouse's plan) ☐ Other, explain here: ________________________________

SECTION III: DEPENDENT INFORMATION proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

SELECT COVERAGE: ☐ **MEDICAL** ☐ **DENTAL/VISION**

☐ SPOUSE ☐ DOMESTIC PARTNER

LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.	DATE OF BIRTH

GENDER ☐ MALE ☐ FEMALE

ENROLLED IN OTHER HEALTH INSURANCE UNDER A GROUP PLAN OR MEDICARE? ☐ YES ☐ NO If yes, please provide the following:

Effective Date of Coverage: _______________

Insurance Carrier: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Other ______________________________

TOTALLY DISABLED? ☐ YES ☐ NO

SELECT COVERAGE: ☐ **MEDICAL** ☐ **DENTAL/VISION**

☐ SON ☐ DAUGHTER

LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.	DATE OF BIRTH

ENROLLED IN OTHER HEALTH INSURANCE UNDER A GROUP PLAN OR MEDICARE? ☐ YES ☐ NO If yes, please provide the following:

Effective Date of Coverage: _______________

Insurance Carrier: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Other ______________________________

TOTALLY DISABLED? ☐ YES ☐ NO

SELECT COVERAGE: ☐ **MEDICAL** ☐ **DENTAL/VISION**

☐ SON ☐ DAUGHTER

LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.	DATE OF BIRTH

ENROLLED IN OTHER HEALTH INSURANCE UNDER A GROUP PLAN OR MEDICARE? ☐ YES ☐ NO If yes, please provide the following:

Effective Date of Coverage: _______________

Insurance Carrier: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Other ______________________________

TOTALLY DISABLED? ☐ YES ☐ NO

SELECT COVERAGE: ☐ **MEDICAL** ☐ **DENTAL/VISION**

☐ SON ☐ DAUGHTER

LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.	DATE OF BIRTH

ENROLLED IN OTHER HEALTH INSURANCE UNDER A GROUP PLAN OR MEDICARE? ☐ YES ☐ NO If yes, please provide the following:

Effective Date of Coverage: _______________

Insurance Carrier: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Other ______________________________

TOTALLY DISABLED? ☐ YES ☐ NO

- I understand it is my responsibility to notify Kenai Drilling Limited once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to Kenai Drilling Limited if claims were paid on behalf of non-eligible individuals.
- **DEDUCTION AUTHORIZATION:** If applicable, I authorize Kenai Drilling Limited to deduct from my wages the required contribution.
- **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- **HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- **EFFECTIVE DATE:** The effective date of coverage is subject to Kenai Drilling Limited approval.

SECTION IV: SIGNATURE OF UNDERSTANDING – REQUIRED

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive Kenai Drilling Limited, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this enrollment/change form and to the best of my knowledge and belief; it is true and accurate with no omissions ormisstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND KENAI DRILLING LIMITED (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND KENAI DRILLING LIMITED ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. KENAI DRILLING LIMITED AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

EMPLOYEE SIGNATURE ____ **DATE** _______________