



CSI INSURANCE PLAN AND TRUST FUND

INSURANCE LIMITED BENEFIT EMPLOYEE APPLICATION FORM

Employee Status : New Hire COBRA Retiree Adding Dependent Deleting Dependent

Effective Date If deleting a dependent (s), which dependent (s) is being deleted?

Employee's Name Soc. Sec. No.

Address City State Zip

Phone Number Date of Employment Sex: M F

Date of Birth Single Married School

Beneficiary's name Soc. Sec. No. Relationship

Beneficiary's address City State Zip

I would like the following coverage:

- Single Limited Benefit (includes Life, AD&D, and LTD) with dental
Single Limited Benefit without dental
Family Limited Benefit (includes Life, AD&D and LTD) with dental
Family Limited Benefit without dental
I am currently covered for dental under my spouse's employer plan.

If choosing Family Limited Benefit (include spouse and all dependent children), please list each eligible dependent:

- 1. Name Birth Date Sex SSN Relationship
2. Name Birth Date Sex SSN Relationship
3. Name Birth Date Sex SSN Relationship
4. Name Birth Date Sex SSN Relationship

I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that the carrier may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense. I hereby certify that I am eligible to participate and that to the best of my knowledge the information given above is correct and true to fact. (For information on eligibility, see below) Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff or leave of absence on the date that the insurance would otherwise become effective. For dependents: Insurance coverage will be delayed if that dependent is totally disabled on the date that the insurance would otherwise be effective. Exception: Infants are insured from live birth.

Signed Date

ELIGIBILITY:

- a. All educational employees who work 500 or more classroom hours per Plan Year must participate in the Plan as of the date of their employment or at the time the school begins participation. All other employees who work 20 or more hours per week (at least 1,000 hours in a Plan Year) are eligible to participate.
b. Any member organization electing to participate in the Limited Benefit Plan (Life, AD&D, and LTD) must enroll 100% of all eligible employees.

Please have your Employer complete. Yearly salary School Number 5439-