To Be Completed By Human Resources:

Optional Life GI Amount $ ____________

Optional Life Amount Requiring EOI Approval $______________

BENEFITS ENROLLMENT FORM

1.PLEASE CHECK THE REASON FOR COMPLETING THIS FORM — PLAN YEAR: JANUARY 1, 2016 – DECEMBER 31, 2016

❑ Initial Enrollment / Date of Hire: Change Effective Date:

❑ Open Enrollment

❑ Beneficiary Change

❑ COBRA Enrollee

❑ Add/Cancel Coverage(s)*

❑ Drop Dependent(s)*

❑ Add Dependent(s): If adding dependents fill in the following dates, as applicable:

-Spouse w/without step children: Date of Marriage:

-Adoptive Children: Date of Placement :

* Reason for Change (i.e., marriage, birth, divorce)

1.PERSONAL INFORMATION

Name (last, first, M.I.) ❑ (check if new name)

Previous Name (last, first, M.I.)

Mailing Address

Date of Birth Social Security #

City State Zip ❑ (check if new address)

Gender Marital Status (Married / Single)

Job Title/Duties Basic Monthly Earnings

Home Phone Work Phone

2.PLEASE SELECT YOUR COMPANY

❑ Accra

❑ Auburn

❑ Brittain Machine, Inc

❑ Division

❑ Exacta Manufacturing

❑ GCM North American Aerospace

❑ Helicomb International, Inc.

❑ Progressive, Inc.

❑ Protective Coatings

❑ SW United - Tulsa

❑ Klune Spanish Fork

❑ University Swaging

❑ Walden’s

❑ Weaver

3.MEDICAL ENROLLMENT INFORMATION

I elect Medical for:	Premera Blue Cross Plan Options		
	QHDHP w. HSA	Buy-Up 1 PPO	Buy-Up 2 PPO
EE Only	❑	❑	❑
EE + SP	❑	❑	❑
EE + Ch(n)	❑	❑	❑
EE +SP + Ch(n)	❑	❑	❑

❑ I waive coverage because I have other coverage

❑ I waive coverage because:

4.DENTAL ENROLLMENT INFORMATION

I elect Dental for:	Delta Dental of WA Plan Options	
	Base PPO	Buy-Up PPO
EE Only	❑	❑
EE + SP	❑	❑
EE + Ch(n)	❑	❑
EE + SP + Ch(n)	❑	❑

❑ I waive coverage

5.VISION ENROLLMENT INFORMATION

I elect Vision for:	Voluntary VSP PPO Plan
EE Only	❑
EE + SP	❑
EE + Ch(n)	❑
EE + SP + Ch(n)	❑

❑ I waive coverage

6.HEALTH SAVINGS ACCOUNT (HSA) ELECTION AMOUNT

Employees who enroll in the QHDHP with Premera Blue Cross may be eligible to participate in the Health Savings Account provided by UMB Bank. You must review and understand UMB Bank's terms and conditions prior to signing this application.

Your HSA Annual Election Amount: $______________

(In addition to the PCC Aerostructures Contribution)

IRS Limits for 2016 are $3,350 for Self Only & $6,750 for Family Coverage

7.PLEASE LIST THE DEPENDENTS YOU WOULD LIKE TO ADD OR DROP: *Spouse or Child*

Add	Drop	Relationship to Employee	Last Name	First Name	M	Social Security Number	Date of Birth	Gender		Benefit Selection		
								M	F	Medical	Dental	Vision
❑	❑	Spouse										
❑	❑	Child										
❑	❑	Child										
❑	❑	Child										
❑	❑	Child										
❑	❑	Child										

Does a dependent have a different mailing address? ❑ No ❑ Yes, complete the following:

Dependent's Name (Last, First, MI) ____

Dependent's mailing address ______________________________ City __________________ State ____ Zip ___________

Is any child over the age of 25 applying for coverage due to disability? ❑ No ❑ Yes, complete and attach the Request for Certification of Disabled Dependent form.

Will any applicant have other current health coverage, including Medicare, which will remain in effect when your coverage begins? ❑ No ❑ Yes

If "yes," name of carrier and policy number: ______________________________ Please confirm if employee, Spouse or Child: ____________________

8.BASIC LIFE & AD&D - SUN LIFE FINANCIAL

A Basic Life and AD&D benefit of $50,000 is provided for you by PCC Aerostructures at no cost to you. Please designate your beneficiaries below:

Beneficiary	**%**	**Relationship**
Beneficiary	**%**	**Relationship**

9.VOLUNTARY SHORT TERM DISABILITY – SUN LIFE FINANCIAL

PCC Aerostructures offers you the opportunity to purchase Short Term Disability insurance. The benefit is contributory, meaning that you are responsible for paying for all of the cost through payroll deduction. To calculate your cost, please refer to the Short Term Disability Benefits Summary.

Employee Coverage: ❑ **I Elect Short Term Disability Coverage** ❑ **I Decline Short Term Disability Coverage**

10.VOLUNTARY LIFE INSURANCE – SUN LIFE FINANCIAL

PCC Aerostructures offers you and your dependents the opportunity to purchase additional Life Insurance through payroll deductions. Evidence of Insurability (EOI) must be submitted for Late Entrants and for New Hires electing amounts over the Guaranteed Issue Amount. A Evidence of Insurability form can be found in your enrollment Packet. Coverage subject to Evidence of Insurability will not go into effect until Sun Life approves it. To calculate your cost, please refer to the Voluntary Life Benefits Summary.

For Yourself: An amount between $10,000 and $500,000, in increments of $10,000 not to exceed five times your basic annual earnings.* Guaranteed Issue Amount: $150,000. Age Reductions: To 65% at age 65 and to 50% at age 70. Benefits cease at retirement.

For your Spouse: An amount between $5,000 and $250,000, in increments of $5,000. Spouse coverage cannot exceed 50% of the employee's Voluntary Life coverage. Guaranteed Issue Amount: $50,000. Age Reductions: To 65% at age 65 and to 50% at age 70.

For your eligible Children: An amount between $2,000 and $10,000, in increments of $2,000 for each eligible child. Child coverage cannot exceed 50% of the employee's Voluntary Life coverage. Coverage for children at or over 14 days old but under 6 months is $500.

	I elect coverage	**I decline coverage**	**Coverage amount selected**
Employee coverage:	❑	❑	$
Spouse/DP coverage:**	❑	❑	$
Child(ren) coverage:**	❑	❑	$

*Basic annual earnings is defined as your salary. Basic annual earnings excludes bonuses, commissions or overtime.
** Your spouse and children may only be covered if you are. If coverage is elected, complete information below:

Your spouse's/DP's name (first, middle initial, last)	**Social Security Number**	**Date of Birth**	**Date of Marriage**

Name(s) of child(ren) to be covered (attach additional pages if needed)	**Date of Birth**

❑ Use my Basic Life beneficiaries—Check this box and leave this section blank if you want your Optional Life Insurance beneficiaries to be the same as your Basic Life beneficiaries

If you did not check the box above, make your beneficiary designation(s) below. If you need more space, attach another sheet to this form. You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds
1.			
2.			
Secondary (Contingent) beneficiary(ies)	**Social Security Number**	**Relationship to employee**	**Percent share of proceeds**
1.			
2.			

11.FLEXIBLE SPENDING ACCOUNTS – ADMINISTERED BY ADP

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses.

❑ **I Choose to Participate in Flexible Spending Accounts**

❑ **I Decline to Participate in Flexible Spending Accounts**

Health Care Expense Account Election Amount: $______________

Email Address:________________________________

Dependent Care Expense Account Election Amount: $________________

***You cannot make or receive Health Savings Account contributions if you enroll in the FSA Health Care Expense Account.**

12. YOUR AUTHORIZATION – PLEASE READ CAREFULLY BEFORE SIGNING

- I have read the information and acknowledge that the sections above represent my enrollment choices. By signing this form, I authorize payroll deductions of the premiums associated with my elections from my paycheck
- I agree that any deduction for premium payments will be paid through pre-tax payroll deduction. Any election I make now will remain in effect during this and all subsequent plan years until I specifically revoke or change my election by completing a new Enrollment Form.
- By signing here, I authorize my healthcare providers to disclose information from my and/or my dependent's medical records to my healthcare carriers, but only to the extent necessary to determine responsibility for payment to be paid and/or for utilization review and quality assurance purposes.
- I agree for myself and my dependents to be bound by the terms of the plan documents under which coverage is provided.
- I understand that I must satisfy the eligibility and actively-at-work requirements on the date of coverage for myself and my eligible dependents.
- I am responsible for reporting to my employer promptly any change in my marital status, in the number of eligible dependents or any change in address.
- I understand that my elections (except Voluntary Life and Voluntary Short Term Disability) are binding for the entire plan year and cannot be altered unless I experience a family status change or qualify for a special open enrollment.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.

Signature:____ Date:________________________