

HY-VEE & AFFILIATES'

2008 GROUP MEMBERSHIP CHANGE FORM - Blue Access/PPO Location

USE BLACK INK ONLY

Changes must be requested within **30** days of the qualifying event date. Changes can be made only if you have had one of the qualifying events as listed on page 2 of this form. Please complete **ALL** areas that relate to your request and send to the Benefit Plan Department at the Hy-Vee office. Any additional forms needed will be sent to you.

Name: _____ Home Telephone: () _____

Address: _____

City: _____ State: _____ Zip Code _____

Please check if new address:

Social Security Number: _____ Work Location: _____

A. Before - Tax Payment Plan (Check one if applicable.) Cannot make a change without an event.

I elect to have my contributions deducted from my wages on a before - tax basis.

I elect to have my contributions deducted from my wages on an after - tax basis.

B. If you wish to change your life insurance beneficiary, please fill out a beneficiary form from the HyVeeNet and send form to us.

C. Is your spouse or parent employed by Hy-Vee or a Subsidiary? Yes No If yes, Name of Work Location: _____

Are you currently covered under a Hy-Vee or Affiliates Health Plan? Yes No

I. Additions to Coverage (*Event Codes listed on page 2 of this form)

Dependent Soc.Sec. #	Dependent Name	M/F	C=child S=spouse	Birthdate (MM/DD/YR)	Event Code*	Event Date	Stepchild	Full-time Student	Stepchild lives with employee 9 mo. of yr.	Social Security Disabled**	Medicare Enrolled**
				/ /		/ /	Y / N	Y / N	Y / N	Y / N	Y / N
				/ /		/ /	Y / N	Y / N	Y / N	Y / N	Y / N
				/ /		/ /	Y / N	Y / N	Y / N	Y / N	Y / N
				/ /		/ /	Y / N	Y / N	Y / N	Y / N	Y / N

** PLEASE ATTACH COPY OF YOUR MEDICARE CARD. **

D. Benefit Options (Please check either a plan choice or waive for each category. Please note that what you elect or waive will be the same for covered spouse and/or dependents.)

Check one box in each category:

Medical/Prescription Blue Access PPO 1200 PPO 2500 Decline Coverage

Dental Yes Decline Coverage

Short Term Disability (employees only) Yes Decline Coverage

Life Insurance Yes Decline Coverage

I understand that if I am covered by my spouse on this plan, I will not have short-term disability as a covered dependent.

Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in medical, dental, STD(employee only), provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

E. Medicare Coverage

Person covered by Medicare: _____

Effective Date (Part A) ____/____/____

Medicare ID (HIC) No. _____

Effective Date (Part B) ____/____/____

H. Prior Coverage Information *If your dependent had previous health care coverage, the former employer is required to provide your dependent with a certificate of creditable coverage which indicates the period of time he or she was covered under that employer's plan. Please attach a copy of the certificate to this form if you have one. If you do not, send the change request to the Benefit Plan department and forward a copy of the certificate as soon as you receive it.*

Did you have health coverage in the last 63 days? Yes No If yes, please complete the following:

Name of Ins. Co.: _____ Policy No.: _____

Covered Person(s): _____ Effective Date: End Date: / / / /
MM DD YR MM DD YR

II. Remove from my Coverage

Please provide current address in "Address Changes" for any removals.

Dependent Soc. Sec. #	Dependent Name	M/F	Birthdate (MM/DD/YR)	Event Code	Event Date
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /

Explanation for Removal _____

Event Codes:	
A - Marriage	I - Divorce - provide
B - Birth of child	proof of date of
C- Adoption of child	divorce
D - Addition of stepchild, foster child, etc.	J - Other - explanation required
E - Addition of child by court order	K** - No longer a full time student
F* - Loss of other group coverage	L- Return to school full time student
G - Death of employee	M - Only STD & Life
H - Death of depen- dent or spouse	N - Other insurance effective and date.

* Must provide certificate of creditable coverage to determine eligibility and pre-existing.
 ** Last date attended school _____

III. Address Changes

Social Security #	Name	New Address

I understand I cannot under any circumstances change my plan choice during the year. I will have the option to change during each annual open enrollment. If I transfer out of an area where my choice (Blue Access or PPO 500) is not available, I will automatically be placed in the equivalent plan (Blue Access or PPO 500). I understand that if I have transferred from the PPO 500 plan to the Blue Access Plan, the provider network will be different. I have read and understand the Agreement and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Signature of Employee: _____ Date: _____

If you or your covered dependent has a work-related illness or injury including self-employed, there is no coverage for that condition through the Hy-Vee and Affiliates Benefits plan.

Premiums

Premiums can be discounted based on non tobacco usage and healthy lifestyle program participation. Premiums will default to full charge until tobacco attestation form (available on HyVeeNet) is received.