

2003 Personalized Enrollment Worksheet (SR1)

Sample Employee

1234 Main Street
Wichita, KS 67208

Social Security Number: 123-45-6789

Gender: F Job Code: 210

Date of Hire: 4/01/2002 Date of Birth: 5/08/1981

Current Elections

If you have no changes, you will automatically be enrolled in these coverages next year. Costs for 2003 are shown for your reference.

Coverage	Plan Name	Coverage Level	2003 Monthly Cost
Medical	PPO PLAN II	Family	\$175.00
Dental	Delta Dental	Employee + 1 Dependent	\$34.38
Vision	Vision Benefits Of America	Employee + 1 Dependent	\$13.80
Basic Life		\$25,000	N/A
Supplemental Life Insurance	Not Enrolled		
Dependent Life Insurance	Not Enrolled		

Coverage Changes

To change or cancel a coverage:

1. Circle your choice in the appropriate premium column.
2. Sign and date the form.
3. Make a copy to verify your choices.

Return in the envelope provided by **November 30, 2002**.

If you don't enroll on time, you will remain in your current coverages. Otherwise, your new choices will be effective **January 1, 2003**.

Medical Coverage & Monthly Costs

Circle premium amount for the plan and coverage you want

Plan Name	Single	Family
(1) PPO Plan II	\$75.00	\$175.00
(2) PPO Plan III	\$40.00	\$100.00
(3) Plan IV (out-of-area)	\$75.00	\$175.00
(4) No coverage		

Dental Coverage & Monthly Costs

Circle premium amount for the plan and coverage you want

Plan Name	Emp Only	Emp + 1 Dependent	Family
(1) Delta Dental	\$17.19	\$34.38	\$49.38
(2) Cancel this coverage.			

Voluntary Plans

Circle premium amount for the Vision plan and coverage you want; circle other coverages as appropriate.

Plan Name	Emp Only	Emp + 1 Dependent	Family
(1) Vision	\$8.25	\$13.80	\$18.80
(2) Cancel this coverage.			

- (3) Supplemental Life Insurance Cancel I wish to enroll. See enclosed enrollment form.
 (4) Dependent Life Insurance Cancel I wish to enroll. See enclosed enrollment form.

Dependent Changes

To change coverage on your dependents, please use the following spaces. If you have no changes you can skip this section.

Name	DOB	Relationship	Add/Terminate	Medical	Dental	Vision
Sample Dependent	9/26/00	Child		Enrolled		

Acknowledgement

Your medical/dental insurance and voluntary benefits must continue through December 31, 2003, unless you have a qualifying change in family status event (see your guide for details).

I understand the benefit choices I have elected for the 2003 Plan Year. I authorize the Plan Sponsor to deduct from my pay any required contribution for the cost of any benefits I indicated above.

Signature _____

Date _____

See the enclosed guide for details on your benefits. Direct questions to Sonic's Benefits Department at (800) 569-6656.

