CERTIFICATE OF DEPENDENT STATUS

To Add New Dependents, it is necessary for you to certify that each of the individuals you are enrolling meets the definition of an eligible dependent under the Medical and/or Dental plans.

All questions on this Certification must be answered for each dependent you are adding.

Once you have determined that these individuals are eligible for participation in the plan(s), you must provide their social security numbers in the space designated on the last page of the Certification form. Please print legibly as this information must be input to our eligibility systems for submission to both CIGNA and the Centers for Medicare and Medicaid Services (CMS).

In order to ensure health coverage for your eligible dependents you must:

- Complete the "Certificate of Dependent Status" (Pages 1-3), including social security information,
- Complete the appropriate enrollment forms for Medical and/or Dental coverage (ORNL-731 and 732),
- Return all forms to the Benefits Service Center at New Hope Center, 602 Scarboro Road, by close of Open Enrollment at **4 p.m. on October 30, 2009.**

If you have questions about eligibility or the certification process, please contact the Benefits Service Center at 865-574-1500 or toll free 1-877-861-2255.

CERTIFICATE OF DEPENDENT STATUS
FOR PURPOSES OF MEDICAL AND DENTAL PLANS

Employee Name	
Employee Date of Birth	Employee Badge/Personnel Number

You are eligible to enroll only certain dependents in the UT-Battelle medical and dental plans. **Note that not all individuals you can claim as tax dependents on your federal income tax return are eligible to participate in these plans.**

PART I.
Please respond to each of the statements in Part I by indicating Y (Yes) or N (No) as appropriate. Then proceed to Part II.

Print Spouse name	Spouse	Answer the following question by indicating Y (yes) or N (no) under the column entitled "Spouse."
		This Dependent is my legal spouse of the opposite sex. (Ex-spouses are not eligible dependents and may not be covered under your medical or dental plan.)

If your response to this question is "Yes," your spouse is an eligible dependent under these plans.

Child Number	Name of Dependent	Date of Birth	Relationship	Type Coverage
01				
02				
03				
04				
05				

Child No. 01	Child No. 02	Child No. 03	Child No. 04	Child No. 05	Answer each question for each child by indicating Y (yes) or N (no) under the applicable column(s).
					The Dependent is my natural child.
					The Dependent is my legally adopted child OR a child legally placed with me for adoption.
					The Dependent is my stepchild.
					The Dependent is my foster child who has been lawfully placed with me by a court order or an authorized placement agency.
					I have legal guardianship, custody or conservatorship by court order or an agreement with a state or other governmental agency.
					The Dependent is recognized as an alternate recipient in a "Qualified Medical Child Support Order" (QMCSO) enforceable with respect to the plan. A child who is recognized as an alternate recipient under a QMCSO is subject to the age requirements noted in Part II, but may not be subject to others.)

If you cannot provide a "yes" response to any of the questions in Part I regarding the child, your dependent is not eligible to participate in these plans.

PART II.

You must also complete Part II if the Dependent is a child unless he/she is eligible to participate in the Welfare Plans pursuant to a QMCSO. Indicate your response for each statement and dependent.

Child No. 01	Child No. 02	Child No. 03	Child No. 04	Child No. 05	Answer each question for each child by indicating Y (yes) or N (no) under the applicable column(s).
					The dependent's marital status is single - unmarried.
					I am the only individual (other than my spouse) who may claim the child as a dependent on my federal income tax return (without regard to any gross income limitations on a dependent), or I may claim the child as my tax dependent even though the child may also be claimed by one or more other individuals. For a description of the regulations related to claiming a child as a tax dependent when the child may also be claimed as a dependent by others and the regulations related to claiming a child as tax dependent after a divorce or legal separation, please see IRS Publication 501 available at www.irs.ustreas.gov or consult your tax advisor.
					I provide over 50% of the child's financial support during the calendar year.
					The child is under age 24 (26 in New Hampshire, 25 in Montana or 25 in Washington) or the child is age 24 or over, but is permanently and totally disabled under plan provisions. (The child may continue to be covered regardless of age provided he or she remains permanently and totally disabled and is primarily dependent upon you for financial support.)
					The child lives with you in a "regular parent-child relationship" for the entire calendar year or at least 50% of the calendar year in the case of a stepchild or the child of divorced parents. The child is considered to have lived with you during periods of time when one of you, or both, are absent due to handicap, disability, illness or education. (A "regular parent-child relationship" means that you are exercising parental authority, responsibility and control over the child by caring for, supporting, disciplining and guarding the child, including making decisions about the child's education and health care. If you are not the child's biological parent, the "parent-child relationship" must be with you, not the child's biological parent.)
					If applicable, the child is a foster child whom I expect to raise to adulthood. (A child who is living with you temporarily or for whom you have temporary custody does not qualify as a foster child. A child who has been placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays for support or maintenance of the child does not qualify as a foster child.)

If you cannot provide a "yes" response to each of these questions or statements in Part II, or a "yes" to each question or statement except the last one and a "not applicable" or "NA" to it, your dependent is not eligible to participate in these plans.

Once you have determined the eligibility status of each of your currently covered dependents, please proceed to the next page and complete the Verification Summary.

VERIFICATION SUMMARY

Relationship	Name of Dependent	Social Security Number (Please print legibly) Enter numbers only - do not use dashes	Meets Eligibility Requirements as Noted Above (Y/N)
Spouse			

Verify the eligibility of each of your dependents as indicated above. For those who continue to meet eligibility requirements, print the social security number in the space provided. Please print legibly as this information must be input to the system for submission to CIGNA and the CMS.

Print, sign and date the Verification Summary below. Return the entire Certificate of Dependent Status (Pages 1-3) to the Benefits Service Center at New Hope Center, 602 Scarboro Road.

I affirm that the contents of this Certificate are true regarding the Dependent(s) to the best of my knowledge, information, and belief. I understand that it is my responsibility to notify the Company within 30 days of the date if the Dependent(s) no longer meets the eligibility requirements for the Welfare Plans. Otherwise, I may be subject to penalties associated with the plan.

I further understand that providing false information on this Certification could result in denial of benefits and/or disciplinary action, including termination of employment.

NOTE: Please keep in mind that you may be asked at any time to provide additional documentation (such as a marriage license, birth certificate, or tax forms) should questions arise regarding a dependent's eligibility for coverage under these plans.

Employee's Signature _____ Date _____

Employee Name	
Employee Date of Birth	Employee Badge/Personnel Number

Print Form Save Form

OPEN ENROLLMENT
October 12, 2009 through October 30, 2009

Benefits Service Center
Post Office Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, Tennessee 37831-2115
Local 865-574-1500
Toll-free 1-877-861-2255
Fax 865-241-0531

Medical
ENROLL, ADD, CHANGE, OR CANCEL FORM

INSURED'S NAME *(First)* *(Middle Initial)* *(Last Name)*	SOCIAL SECURITY NO.		BADGE
STREET	CITY	STATE	ZIP CODE
EMPLOYER (NAME OF COMPANY)	PAYROLL ☐ Hourly ☐ Weekly ☐ Monthly		EFFECTIVE DATE January 1, 2010

STATUS

☐ ACTIVE ☐ RETIRED ☐ SPOUSE OF A RETIREE ☐ SPOUSE OF A DECEASED RETIREE
☐ LONG TERM DISABILITY ☐ DISPLACED DEFENSE WORKER ☐ 3-MONTH CONTINUATION ☐ SPOUSE OF A DECEASED EMPLOYEE
☐ COBRA

IF RETIRED, DO YOU HAVE 10 YEARS OF FULL-TIME COMPANY SERVICE? ☐ YES ☐ NO

COMPANY SERVICE DATE

IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SOCIAL SECURITY NO.

COVERAGE TYPE
☐ CIGNA OPEN ACCESS ☐ CIGNA POS ☐ CIGNA INDEMNITY

COVERAGE LEVEL
☐ INDIVIDUAL ☐ DUAL ☐ FAMILY

EMPLOYEES
I ELECT TO HAVE THIS DEDUCTION MADE ON A BEFORE-TAX BASIS FROM MY WAGES.
☐ YES ☐ NO

RETIREES
I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT.
☐ YES ☐ NO

LONG TERM DISABILITY PARTICIPANTS
I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY DISABILITY PAYMENT.
☐ YES ☐ NO

MEDICAL INSURANCE ENROLLMENT INFORMATION

INSTRUCTIONS Complete this section to:
- Add or cancel a dependent from your medical insurance
- Select your Primary Care Physician on initial enrollment. *(Required for CIGNA POS; optional for CIGNA Open Access)*
- Make changes to your dependents' personal information such as spelling of name or date of birth.

If you are adding or canceling coverage of a dependent, you must indicate a reason in the space provided.

PLEASE NOTE *-Changes to your medical insurance cannot take effect until you return this enrollment form to:*
Benefits Service Center
P.O. Box 2115, 602 Scarboro Road, MS-8258, Oak Ridge, TN 37831-2115

First Name	Last Name	Date of Birth	Sex	**Relationship** (Spouse, Son, Daughter, or Handicapped Child Over Age 24)	**Primary Care Physician** ***Enter ID Number for either CIGNA option.***	Current Patient? (yes/no)	Enroll , Add, Change or Cancel Coverage
				Self			Enroll

REASON FOR ADDING OR CANCELING COVERAGE
I understand that any additions to the medical plan must be added within 30 days of the qualifying event. If it is more than 30 days, the addition can only be made during an open enrollment. I can cancel coverage at any time, however, if there is not a qualifying event or it is more than 30 days since the qualifying event, I understand that if the premium is deducted from my pay on a pretax basis, the deduction will not be changed or cancelled until the next calendar year.

REASON FOR CHANGE

☐ MARRIAGE — DATE OF MARRIAGE
☐ BIRTH OR ADOPTION ***(A copy of the adoption papers signed by the court must be provided.)*** — DATE OF BIRTH OR ADOPTION
☐ DIVORCE ***(A copy of the divorce decree signed by the court official must be provided.)*** — DATE OF DIVORCE
☐ DEPENDENT LOST ELIGIBILITY STATUS *(Complete COBRA Information Worksheet, UCN-20898.)* — DATE OF EVENT
☐ CHANGE OF EMPLOYMENT STATUS *(Self or Spouse)* — DATE OF EVENT
☒ OTHER EXPLAIN BELOW — DATE OF EVENT

OTHER CHANGE EXPLANATION
OPEN ENROLLMENT

SIGNED | DATE

ORNL-731 (10/2009)

Customer Service Representatives are available Monday through Thursday from 7:00 a.m. to 5:00 p.m. Eastern Time.

Print Form Save Form

OPEN ENROLLMENT
October 12, 2009 through October 30, 2009

Dental

ENROLL, ADD, CHANGE, OR CANCEL FORM

Benefits Service Center
Post Office Box 2115
602 Scarboro Road, MS-8258
Oak Ridge, Tennessee 37831-2115
Local 865-574-1500
Toll-free 1-877-861-2255
Fax 865-241-0531

one·call

INSURED'S NAME *(First)* *(Middle Initial)* *(Last Name)*	SOCIAL SECURITY NO.		BADGE
STREET	CITY	STATE	ZIP CODE
EMPLOYER (NAME OF COMPANY)	PAYROLL ☐ Hourly ☐ Weekly ☐ Monthly		EFFECTIVE DATE January 1, 2010

STATUS

☐ ACTIVE ☐ RETIRED ☐ SPOUSE OF A RETIREE ☐ SPOUSE OF A DECEASED RETIREE
☐ LONG TERM DISABILITY ☐ DISPLACED DEFENSE WORKER ☐ 3-MONTH CONTINUATION ☐ SPOUSE OF A DECEASED EMPLOYEE
☐ COBRA

IF RETIRED, DO YOU HAVE 10 YEARS OF FULL-TIME COMPANY SERVICE? ☐ YES ☐ NO

COMPANY SERVICE DATE

IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SOCIAL SECURITY NO.

COVERAGE TYPE
☐ METROPOLITAN LIFE ☐ DELTA DENTAL

COVERAGE LEVEL
☐ INDIVIDUAL ☐ DUAL ☐ FAMILY

EMPLOYEES
I ELECT TO HAVE THIS DEDUCTION MADE ON A BEFORE-TAX BASIS FROM MY WAGES.
☐ YES ☐ NO

RETIREES
I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT.
☐ YES ☐ NO

LONG TERM DISABILITY PARTICIPANTS
I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY DISABILITY PAYMENT.
☐ YES ☐ NO

INSTRUCTIONS

Complete this worksheet to enroll, add, or cancel a dependent from your dental insurance, or make changes to your dependents' personal information (such as name spelling or date of birth). If you are adding or canceling coverage on a dependent, you must indicate a reason in the area below the grid.

PLEASE NOTE *-Changes to your dental insurance cannot take effect until you return this enrollment form to:* **Benefits Service Center** P.O. Box 2115, 602 Scarboro Road, MS-8258, Oak Ridge, TN 37831-2115

DENTAL INSURANCE ENROLLMENT INFORMATION

First Name	Last Name	Date Of Birth	Sex	Relationship Spouse, Son, Daughter, or Handicapped Child Over Age 24	Enroll , Add, Change or Cancel Coverage
				Self	ENROLL

REASON FOR ADDING OR CANCELING COVERAGE

I understand that any additions to the dental plan must be added within 30 days of the qualifying event. If it is more than 30 days, the addition can only be made during an open enrollment. I can cancel coverage at any time, however, if there is not a qualifying event or it is more than 30 days since the qualifying event, I understand that if the premium is deducted from my pay on a pre-tax basis, the deduction will not be changed or cancelled until the next calendar year.

REASON FOR CHANGE

☐ MARRIAGE — DATE OF MARRIAGE
☐ BIRTH OR ADOPTION *(A copy of the adoption papers signed by the court must be provided.)* — DATE OF BIRTH OR ADOPTION
☐ DIVORCE *(A copy of the divorce decree signed by the court official must be provided.)* — DATE OF DIVORCE
☐ DEPENDENT LOST ELIGIBILITY STATUS — DATE OF EVENT
☐ CHANGE OF EMPLOYMENT STATUS *(SELF OR SPOUSE)* — DATE OF EVENT
☒ OTHER EXPLAIN BELOW — DATE OF EVENT

OTHER CHANGE EXPLANATION
OPEN ENROLLMENT

SIGNED DATE

ORNL-732 (10/2009)

Customer Service Representatives are available Monday through Thursday from 7:00 a.m. to 5:00 p.m. Eastern Time.

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