

ICON HEALTH AND FITNESS

EMPLOYEE INFORMATION			SOCIAL SECURITY NUMBER	BIRTHDATE	EMPLOYEE #	EMPLOYER USE ONLY	
LAST NAME	FIRST NAME	M.I.				MEDICAL GROUP	DENTAL GROUP
STREET ADDRESS		APT. #	CITY	STATE	ZIP		
HOME PHONE ()	EMERGENCY PHONE ()		<input type="checkbox"/> SINGLE	<input type="checkbox"/> SALARY/EXEMPT	TOBACCO USE		
WORK LOCATION	JOB TITLE		<input type="checkbox"/> MARRIED	<input type="checkbox"/> HOURLY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
			AVERAGE HOURS WORKED _____		HOW MANY MEMBERS _____		

REASON FOR COMPLETING FORM		BENEFIT SELECTIONS (CHECK ALL THAT APPLY)				
ENROLLMENT/CHANGE OF STATUS: <input type="checkbox"/> NEW HIRE DATE _____ <input type="checkbox"/> REHIRED DATE _____ <input type="checkbox"/> TRANSFER FROM _____ <input type="checkbox"/> LIFE STYLE CHANGE <input type="checkbox"/> ANNUAL ENROLLMENT	EFFECTIVE DATE _____ MEMBERSHIP STATUS _____ ADULT CODE _____ FAMILY MEMBERS _____ SPECIAL CODE _____ MEDICALLY UNDERWRITTEN _____	MEDICAL BENEFITS: <input type="checkbox"/> *HSA <input type="checkbox"/> *BCBS Traditional <input type="checkbox"/> PPO <input type="checkbox"/> SINGLE MEDICAL COVERAGE <input type="checkbox"/> FAMILY MEDICAL COVERAGE <input type="checkbox"/> TWO PARTY <input type="checkbox"/> NO MEDICAL COVERAGE		DENTAL BENEFITS: <input type="checkbox"/> SINGLE DENTAL COVERAGE <input type="checkbox"/> TWO-PARTY DENTAL COVERAGE (INDICATE THOSE BELOW) <input type="checkbox"/> FAMILY DENTAL COVERAGE <input type="checkbox"/> NO DENTAL COVERAGE		SUPPLEMENTAL LIFE BENEFITS: (Complete SLB application) Please complete another application if you are wanting additional Life Coverage.
		ADDITIONAL BENEFITS: <input checked="" type="checkbox"/> BASIC LIFE AND AD&D INSURANCE (\$10,000) <input checked="" type="checkbox"/> DEPENDENT LIFE (\$2,000)		FLEXIBLE SPENDING ACCOUNTS: <input type="checkbox"/> HEALTH CARE REIMBURSEMENT ACCOUNT You may elect a monthly amount in \$5 increments up to \$400. \$ _____ <input type="checkbox"/> DEPENDENT CARE REIMBURSEMENT ACCOUNT You may elect a monthly amount in \$20 increments up to \$400. \$ _____ <input type="checkbox"/> I DO NOT WISH TO PARTICIPATE IN THE SECTION 125 PREMIUM ONLY PLAN (If this box is checked, your benefit deductions will be taxable.)		LONG TERM DISABILITY (Complete LTD application) Please complete another application if you are wanting Long Term Disability Coverage.

FAMILY INFORMATION						
SEX	LEGAL LAST NAME	FIRST NAME	M.I.	BIRTHDATE	SOCIAL SECURITY NUMBER	DENTAL COVERAGE
<input type="checkbox"/> M <input type="checkbox"/> F	SELF					
<input type="checkbox"/> M <input type="checkbox"/> F	SPOUSE					
<input type="checkbox"/> M <input type="checkbox"/> F	CHILD					
<input type="checkbox"/> M <input type="checkbox"/> F	CHILD					
<input type="checkbox"/> M <input type="checkbox"/> F	CHILD					
<input type="checkbox"/> M <input type="checkbox"/> F	CHILD					
<input type="checkbox"/> M <input type="checkbox"/> F	CHILD					

BENEFICIARY DESIGNATION			
BENEFICIARY FULL NAME (To be paid at 18 years or older.)	RELATIONSHIP	CONTINGENT BENEFICIARY	RELATIONSHIP

OTHER HEALTH INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

ON THE DAY your coverage begins or within the last 63 days have any family members, including those not listed above, been covered by other health or dental insurance or Medicare?

NO YES — If yes, ask for the corresponding form.

SIGNATURE AND AUTHORIZATION

I hereby enroll for or decline the benefit coverage(s) as indicated on this application and authorize ICON, Inc., to make the necessary payroll deductions. It is understood that this election will be in effect until the next enrollment period, when I will have another opportunity to make an election. I have read the accompanying materials describing the various benefit Plans and understand that my eligibility, participation and entitlement to coverage is subject to the terms and conditions as described in the Plan contracts and/or Summary Plan Descriptions. I also acknowledge that my elections will be effective during the Plan Year in which I enroll or become eligible unless I have a family status change and that it is my responsibility to inform the Human Resources Department within 30 days of any changes to the information provided above. I authorize any source to release to the Claims Administrator any medical, health, employment and/or insurance information requested on any enrolled member. I certify by my signature that the information I have given is true and accurate to the best of my knowledge and understand that any misrepresentation or falsification, intentional or otherwise in order to obtain coverage, may result in disciplinary action by my employer and/or forfeiture of benefits. I accept binding arbitration as the method of resolving any disputes arising between me or the covered family members of the Plan. I understand that my employer or its representatives are not acting as an agent for any carrier.

SIGNATURE _____ DATE _____

*In Utah: Regence BlueCross BlueShield of Utah Network

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