401k Enrollment

Social Security Number _____ Contract# 513304

☐ I elect to contribute.
I will enroll using one of the on-line enrollment methods provided by TransAmerica. (On the web TA-Retirement.com or by phone 1-800/401/TRAN (8726).
Be sure to keep your login and password secure at all times to prevent fraud!

☐ I would like to request the Benefits Director auto enroll me into the TA website. I understand that I will still need to contact TA to assign my vesting information. I would like to contribute _____ $/% amount.

☐ I elect **not** to contribute at this time.
I acknowledge that if I have selected the "I elect not to contribute" box on this form, I will not be making any contributions to the plan. Note: Enrollment is available monthly after completion of your wait period. Contact your plan administrator for information.

☐ If you had prior employment with ESTOO, Indigo Sky, or Outpost Casino in the past five (5) years and participated in the 401k plan, please notify the Benefits Director immediately.
_____ (initial).

To consolidate any/all retirement accounts. Call TransAmerica 800-401-8726 for assistance.

I acknowledge that this plan offers investment options through my company's group annuity contract with TransAmerica and that I have read and understand the instructions that accompany this form. I agree to maintain secure methods to prevent access to my online account.

Signature of Participant	Print Name	Date

Eastern Shawnee Tribe of Oklahoma- Grp# 16723

Effective Date

Employee Name (Last, First, Middle) | ☐ Male ☐ Female | Date of Birth | **Social Security Number** | Home ( ) | Cell ( ) | Email:

Employee Street Address | City, State | Zip Code | ☐ Hired Full Time ☐ Rehired Full Time | Date | Work Dept: | Location: ☐ Admin-T ☐ Indigo ☐ Outpost ☐ Surv/Gaming | ☐ Single ☐ Married ☐ Legally Separated ☐ Widowed ☐ Divorced

☐ I *Request* Medical/RX/Dental/Vision Coverage
☐ I *Request* Dental ONLY Coverage
☐ I *Request* Vision ONLY Coverage : Basic or Buy-up
(Circle 1)

☐ I *Decline* Employee Medical/RX Coverage
☐ I *Decline* Employee Dental Coverage
☐ I *Decline* Employee Vision Coverage
WHY:

Documentation Presented:
☐ **Enrollment Packet rec'd**

Signature below indicates these documents received during enrollment.

Enrollment packet MUST be completed even if denying coverage.
Basic Life and Basic Vision coverage is free to employee.

Record any current insurance coverage
☐ Indian-CDIB ☐
☐ ☐ Gov't Assist

Medical/ RX/ Dental / Vision Coverage		Medical/ RX Coverage		Dental ONLY Coverage		BASIC Visione		BUY-UP Vison		**MUST LIST ALL DEPENDENTS** **Dependent Definition:** *Your lawful spouse unless legally separated and your children to age 26 who have no access to other insurance.*			Dependent Address (if different than one above):		
REQUEST	DECLINE	REQUEST	DECLINE	REQUEST	DECLINE	REQUEST	DECLINE	REQUEST	DECLINE	**Eligible Dependent(s):** **Name:** Last, First, M)	**Sex** M/F	Date of Birth	**Social Security** Number	INDIAN-CDIB	**Record any MED/DENTAL insurance coverage**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Spouse:					
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Child:					
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Child:					
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Child:					
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Child:					

Fraud required by some states: Any person who knowingly and with intent to defraud the plan other person files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act which is a crime. I hereby enroll for the coverage for which I am now or may become eligible under my employer's plan, and hereby authorize my employer to deduct from my earnings the required contributions. If any. Falsification of this form could affect employment status.

Signature of Employee:_____ Date Signed_____

This form **MUST** be returned to the Benefits Office by the 15th of the month to meet enrollment timeline.

Employer Name: Eastern Shawnee Tribe of OK

MAA Group No. 16723

Employee Name: _____

FOR USE WITH GRANDFATHERED PLANS

ENROLLMENT INFORMATION FOR ADULT CHILDREN

For adult children between the ages of 19 and 26, please complete the following form. A separate form is required for each child between the ages of 19 and 26.

NOTE: Adult children between the ages of 19 and 26 are not eligible for enrollment on the Plan if such child is eligible for other employer sponsored coverage that is not sponsored by a parent's employer. In the event such child becomes eligible for other employer sponsored coverage, it is the responsibility of the employee to immediately notify the Plan of such eligibility. Any failure to notify the Plan will be considered a willfully false statement material to the coverage being provided and shall form a basis for rescission of coverage for such adult child.

ADULT CHILD INFORMATION:

Full Legal Name: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ Telephone No. (with area code): _____

Does the adult child above have other coverage under another parent? ☐ YES ☐ NO - If yes, please provide the name, address and phone number of the insurance company along with the policy number on the back of this form.

****

AFFIDAVIT OF PARENT OR LEGAL GUARDIAN:

The undersigned does hereby affirm upon oath the following information:

- The undersigned is of legal age and competent to execute this Affidavit;
- The undersigned has personal knowledge of the facts stated herein;
- The undersigned is aware that these statements are being made under oath and that any willfully false statements made herein will result in denial or rescission of coverage for adult child or enrolled child and any other recourse lawfully available to the Plan;
- The undersigned is the parent or legal guardian of the enrolled child(ren) named;
- The information concerning the enrolled child(ren) are true and accurate to the best of my knowledge and belief;
- The above adult child is not eligible for health insurance coverage through any employer sponsored health plan other than a health plan sponsored by a parent's employer;
- The undersigned understands, acknowledges and agrees that he/she has a responsibility to immediately notify the Plan if the above adult child becomes eligible for health insurance coverage through any employer sponsored health plan other than a health plan sponsored by a parent's employer.

_____ Date

_____ SIGNATURE/ PARENT OR LEGAL GUARDIAN

Health Insurance Portability and Accountability Act

During the course of performing assigned duties at the Eastern Shawnee Tribe of Oklahoma/ Indigo Sky Casino/ Outpost Casino/ Bordertown Arena, the Benefits Office may have access to confidential health information. We hereby agree to handle such information in a confidential manner at all times during and after employment. We understand that the use and disclosure of patient information is governed by the rules and regulations established under HIPAA, the Health Insurance Portability and Accountability Act of 1996.

Notice of Special Enrollment Rights for your Medical Plan

If you decline 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 this plan, provided that you request coverage within 30 days after your other coverage ends. You must provide written documentation of the termination of the other coverage. Please note: "If you lose other coverage for failing to pay premiums or due to making fraudulent claims, you will not have a Special Enrollment Right."

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and your newly acquired dependents, provided that you request coverage within 30 days after the date of the marriage, birth, adoption or placement for adoption.

If you and your eligible dependents enroll during a **Special Enrollment Period**, as described above, you are not considered a late enrollee.

Additional Special Enrollment provision in connection with Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA):

Additional Special Enrollment Rights: This Plan will permit employees and dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee request coverage under the plan within 30 days after termination, or
2. the employee or dependent become eligible for a premium assistance subsidy under Medicare or CHIP, and the employee requests coverage under the plan within 30 days after eligibility is determined.

Employee's printed name _____ Group# 76-412125

Employee's signature _____ SS# _____

Witnessed by: _____

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-017943-00

Employer/Policyholder Name Eastern Shawnee Tribe of Oklahoma

12755 West Oneida Street (Street Address) | Wyandotte (City) | OK (State) | 74370 (Zip Code)

Employee Occupation/Job Title

Employee Date of Employment

Effective Date of Coverage

☑ Full Time Employee

$ _____ / ○ HR ○ WK ○ MO ○ YR
Basic Earnings

Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

Name — Sex ○ M ○ F

Street Address | City | State | Zip Code

Home Telephone Number | Date of Birth | Marital Status

II. BENEFITS (Please check if you wish to enroll)

	Yes	No	Indicate the benefit amount
Employee Life	✔	☐	_____ x BAE[1] or $ 25,000
Employee AD&D	✔	☐	_____ x BAE[1] or $ 25,000
Employee Supplemental Life	☐	☐	_____ x BAE[1] or $ _____
Employee Supplemental AD&D	☐	☐	_____ x BAE[1] or $ _____
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
Spouse[2]	☐	☐	_____ x BAE[1] or $ _____
Child[2]	☐	☐	_____ x BAE[1] or $ _____

[1] *BAE: Basic Annual Earnings as defined in your contract.* [2] *List Dependents' names and birthdates (use another page if needed).*

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

Important rules:

1) If you decline coverage at your initial enrollment, you will need to complete an EOI for yourself and spouse to get coverage later.
2) Coverage ends if 1) your failure to pay, 2) Your employment ends, or 3) spouse coverage ends due to divorce. You MUST report ineligibility. No premium refunds.
3) Spouse/child does not qualify while on active duty, insured as an employee under same plan; no dual coverage allowed for spouse or children under this plan. You MUST report ineligibility. No premium refunds.
4) Prudential does not track child age, you MUST report ineligibility. No premium refunds.
5) Deaths MUST be reported within 30 days.
6) Enrollment declined if 80+ years old.
7) Rates are subject to change with increased age band.

Group Benefits are insured by Symetra Life Insurance Company.

Bi-Monthly Payroll Deductions

EMPLOYEE LIFE & AD&D RATES

	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	Rates	
Age Band											Bi Monthly	Monthly
0-24	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50	0.045	0.09
25-29	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50	0.045	0.09
30-34	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50	0.055	0.11
35-39	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50	0.075	0.15
40-44	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00	0.110	0.22
45-49	$1.75	$3.50	$5.25	$7.00	$8.75	$10.50	$12.25	$14.00	$15.75	$17.50	0.175	0.35
50-54	$2.90	$5.80	$8.70	$11.60	$14.50	$17.40	$20.30	$23.20	$26.10	$29.00	0.290	0.58
55-59	$4.45	$8.90	$13.35	$17.80	$22.25	$26.70	$31.15	$35.60	$40.05	$44.50	0.445	0.89
60-64	$6.05	$12.10	$18.15	$24.20	$30.25	$36.30	$42.35	$48.40	$54.45	$60.50	0.605	1.21
65-69	$9.65	$19.30	$28.95	$38.60	$48.25	$57.90	$67.55	$77.20	$86.85	$96.50	0.965	1.93
70-74	$17.10	$34.20	$51.30	$68.40	$85.50	$102.60	$119.70	$136.80	$153.90	$171.00	1.710	3.42
75+ <80	$29.40	$58.80	$88.20	$117.60	$147.00	$176.40	$205.80	$235.20	$264.60	$294.00	2.940	5.88

SPOUSE LIFE RATES

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$50,000	Rates	
Age Band										Bi-Monthly	Monthly
0-24	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.75	0.035	0.07
25-29	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.75	0.035	0.07
30-34	$0.23	$0.45	$0.68	$0.90	$1.13	$1.35	$1.58	$1.80	$2.25	0.045	0.09
35-39	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$3.25	0.065	0.13
40-44	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$5.00	0.100	0.2
45-49	$0.83	$1.65	$2.48	$3.30	$4.13	$4.95	$5.78	$6.60	$8.25	0.165	0.33
50-54	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$14.00	0.280	0.56
55-59	$2.18	$4.35	$6.53	$8.70	$10.88	$13.05	$15.23	$17.40	$21.75	0.435	0.87
60-64	$2.98	$5.95	$8.93	$11.90	$14.88	$17.85	$20.83	$23.80	$29.75	0.595	1.19
65-69	$4.78	$9.55	$14.33	$19.10	$23.88	$28.65	$33.43	$38.20	$47.75	0.955	1.91
70-74	$8.50	$17.00	$25.50	$34.00	$42.50	$51.00	$59.50	$68.00	$85.00	1.700	3.4
75+ <80	$14.65	$29.30	$43.95	$58.60	$73.25	$87.90	$102.55	$117.20	$146.50	2.930	5.86

CHILD LIFE RATES

6M-26Y	$10,000
15D-6M	$100.00
	$1.00

1.000

does not track child age, you MUST report ineligibility.

NOTE: FINAL RATES MAY VARY SLIGHTLY DUE TO ROUNDING.

Coverage will begin to reduce after age 65Y, 65%. At 70Y, 50%.

THESE GRIDS ARE PRICES OF FREQUENTLY SELECTED AMOUNTS. YOU MAY CHOOSE
ANY INCREMENT OF $10,000 UP TO $500,000.(NOT TO EXCEED 5 TIMES YOUR ANNUAL SALARY)
FOR SPOUSE ANY INCREMENT OF $5,000 UPTO $50,000 (NOT TO EXCEED 50% OF EMPLOYEE LIFE AMOUNT)
THE GUARANTEE ISSUE AMOUNT FOR EMPLOYEES IS $100,000 AND SPOUSE $30,000

1/2017

GUARDIAN®

The Guardian Life Insurance Company of America

And its Affiliates and Subsidiaries

Midwest Regional Office
P.O. Box 14319, Lexington, KY 40512

Enrollment/Change Form

Please print clearly and mark carefully.

Employer Name:
Eastern Shawnee Tribe of Oklahoma

Group Plan Number: **00536077**
Benefits Effective:

PLEASE CHECK APPROPRIATE BOX
☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change
☐ Increase Amount ☐ Family Status Change

Class: Division:
(Please obtain this from your Employer)

About You:
First, MI, Last Name:

Social Security Number

Address/City/State/Zip:

Gender: M ☐ F ☐ Date of Birth (mm-dd-yy): Phone: ( )

Email Address:

Are you married or do you have a spouse? ☐ Yes ☐ No Date of marriage/union:
Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child:

About Your Job:
Hours worked per week: Job Title:

Work Status:
☐ Active ☐ Retired ☐ Cobra/State Continuation

Date of full time hire:

Annual Salary: $

About Your Family: **Please include the names of the dependents you wish to enroll for coverage.** ***Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.***

Spouse (First, MI, Last Name)
Gender ☐M ☐F
Social Security Number
Address/City/State/Zip:
Date of Birth (mm-dd-yyyy)
Phone: ( )

Child/Dependent 1:
☐ Add ☐ Drop
Gender ☐M ☐F
Social Security Number
Status (check all that apply)
☐ Student (post high school)
☐ Disabled
☐ Non standard dependent
Address/City/State/Zip:
Date of Birth (mm-dd-yyyy)
Phone: ( )

Child/Dependent 2:
☐ Add ☐ Drop
Gender ☐M ☐F
Social Security Number
Status (check all that apply)
☐ Student (post high school)
☐ Disabled
☐ Non standard dependent
Address/City/State/Zip:
Date of Birth (mm-dd-yyyy)
Phone: ( )

Child/Dependent 3:
☐ Add ☐ Drop
Gender ☐M ☐F
Social Security Number
Status (check all that apply)
☐ Student (post high school)
☐ Disabled
☐ Non standard dependent
Address/City/State/Zip:
Date of Birth (mm-dd-yyyy)
Phone: ( )

Child/Dependent 4:	☐ Add ☐ Drop	Gender ☐M ☐F	Social Security Number ___ - ___ - ___	Status (check all that apply)
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ___ - ___ - ___	☐ Student (post high school)
Phone: ( ) -				☐ Disabled
				☐ Non standard dependent

Critical Illness Coverage: You must be enrolled to cover your dependents.

Benefit reductions apply. Please see plan administrator.

Core
Insurance Amount :
☐ $5,000 ☐ $10,000 ☐ $15,000

☐ I do not want this coverage.

Spouse
Insurance Amount
☐ 100% of the employee's amount
The amount may not be more than 100% of Employee Amount.
☐ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount:
☐ 25% of employee's amount
The amount may not be more than 25% of Employee Amount.
☐ I do not want this coverage.

Important Notes:

- Based on your plan benefits and age you may be required to complete an additional evidence of insurability form for Critical Illness.

Accident Coverage: You must be enrolled to cover your dependents. Check only one box.

Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
☐ $12.30	☐ $17.86	☐ $19.35	☐ $24.91
☐ I do not want this coverage.	☐ I do not want this coverage.	☐ I do not want this coverage.	☐ I do not want this coverage.

Employee - Name your beneficiaries: (primary beneficiary percentages must total 100%)
Primary Beneficiaries:

Name: _____ **Social Security Number:** ___ - ___ - ___ % ___
Date of Birth (mm-dd-yy): ___ - ___ - ___ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____

Name: _____ **Social Security Number:** ___ - ___ - ___ % ___
Date of Birth (mm-dd-yy): ___ - ___ - ___ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____

Contingent Beneficiary Name: _____ **Social Security Number:** ___ - ___ - ___ % ___
Date of Birth (mm-dd-yy): ___ - ___ - ___ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____ (In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Cancer Coverage: You must be enrolled to cover your dependents. Check only one box.

Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
☐ $14.78	☐ $29.36	☐ $17.65	☐ $32.22
☐ I do not want this coverage.			

Complete the following question if you are enrolling for Cancer coverage. NOTE: Additional information may be required.

Has anyone to be covered been treated for or diagnosed as having Cancer in any form, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) within the last 5 years?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse has. ☐ No, my spouse hasn't.
☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

Hospital Indemnity Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Plan Option 1	☐ $22.25	☐ $39.27	☐ $25.48	☐ $42.50

Applicants over the age of 69 are not eligible to enroll in Hospital Indemnity coverage.

☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage.

Important Notes:

This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for, hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

Signature

- An employee's decision to elect Hospital Indemnity or not elect Hospital Indemnity must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in the Hospital Indemnity coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay apply premiums to my credit card or debit card, or add premiums to my dues, if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** ☐

CI

Semi-monthly Premiums Displayed
Election Cost Per Age Bracket

Issue Age	< 30	30-39	40-49	50-59	60-69	70+
$5,000 Benefit Amount						
Employee $5,000	$1.76	$2.06	$3.11	$4.91	$7.01	$14.41
Spouse $5,000	$1.76	$2.06	$3.11	$4.91	$7.01	$14.41
$10,000 Benefit Amount						
Employee $10,000	$2.94	$3.54	$5.64	$9.24	$13.44	$28.24
Spouse $10,000	$2.94	$3.54	$5.64	$9.24	$13.44	$28.24
$15,000 Benefit Amount						
Employee $15,000	$4.11	$5.01	$8.16	$13.56	$19.86	$42.06
Spouse $15,000	$4.11	$5.01	$8.16	$13.56	$19.86	$42.06

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals , for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

☐ Tribal Adm
☐ IS Casino
☐ Outpost
☐ Bordertown Arena
☐ Surv.

Eastern Shawnee Tribe of Oklahoma
Enrollment Form

Return this form to your benefits administrator.

Employee Name: _____ **Employee Gender:** _____
Last Name, First Name, Middle Initial

Employee Social Security Number: _____ **Date of Birth** _____

Basic Plan	**Buy-up Plan**
Type of coverage selected:	**Type of coverage selected:**
◯ **Employee only** ***(Paid by ESTOO)***	◯ **Employee only $7.88/mo**
◯ **Employee +1 dependent (spouse or child) $0.60/mo**	◯ **Employee +1 dependent (sp or child) 13.22/mo**
◯ **Employee plus two $0.62/mo**	◯ **Employee plus two $13.50/mo**
◯ **Employee plus family $1.65/mo**	◯ **Employee plus family $22.38/mo**

☐ **Waive Coverage**

_____ _____
Employee Signature **Date**

Clients: This form provided for your internal use only. Please do not return to VSP. Thank you.

This form MUST be returned to the Benefits Office by the 15th of the month to meet enrollment timeline.

- [ ] Tribal Adm
- [ ] IS Casino
- [ ] Outpost
- [ ] Surv

Date Effective _____

Payroll deductions

Per Pay Check	Per Mo.	
		Health Insurance
		Dental Insurance
		Vision – Basic
		Vision – Buy Up
		Life Insurance
		Guardian Pre-tax
		Guardian Critical Illness Post-tax

E only	E+S	E+C	E+F
25.00	200.00	75.00	275.00
Emp Dental Only	E+S	E+C	E+F
2.50	8.15	12.85	22.85
	E+1	E+2 (children)	E+F
	0.30	0.31	0.82
E	E+1	E+2 (children)	E+F
3.94	6.61	6.75	11.19

Accident Pre-tax	E only	E+S	E+C	E+F
	$12.30	$17.86	$19.35	$24.91
Cancer Pre-tax	E only	E+S	E+C	E+F
	$14.78	$29.36	$17.65	$32.22
Hosp. Ind. Pre-tax	E only	E+S	E+C	E+F
	$22.25	$39.27	$25.48	$42.50
	$49.33	$86.49	$62.48	$99.63

Issue Age:	<30	30-39	40-49	50-59	60-69	70+
$5000 E/S (each)	$1.76	$2.06	$3.11	$4.91	$7.01	$14.41
$10,000 E/S (each)	$2.94	$3.54	$5.64	$9.24	$13.44	$28.24
$15,000 E/S (each)	$4.11	$5.01	$8.16	$13.56	$19.86	$42.06

Semi monthly

I authorize my employer to deduct the required contributions for any elected options, as listed above, from my pay check.

Signature: _____ Date: _____

Name: _____

Department: _____