

Smart Choices Enrollment and Change of Coverage Form Directions

Before you begin, please check the eligibility information that is provided in your Smart Choices Highlights Brochure for medical, dental and flexible spending account benefits. (Your eligibility for coverage must be verified by UCAR).

Complete your enrollment form in ballpoint pen. Print clearly and firmly so your information is readable and appears on all copies of the form.

DO NOT FILL IN THE SHADED AREAS ON YOUR ENROLLMENT FORM

NEW ENROLLMENT INSTRUCTIONS for all eligible UCAR participants.

1. Complete Sections I and II.
2. Complete Section III for yourself and all of your covered dependents, if you are changing plans or if your dependent coverage has changed since last year (adding or dropping dependent coverage), or if you are enrolling in UCAR's health insurance plan for the first time.

When completing Section III, fill in your name, date of birth, Social Security number and sex. **If you choose Option I**, fill in your Primary Care Physician's name and ID number from your Provider Directory. A hard copy of the directory can be obtained from the Human Resources office or you may visit on-line at www.cigna.com. Indicate whether or not this doctor is your current physician by responding with a "Y" or "N" in the far right column of the form. For applicable dependents, fill in the same information as stated above. You may be required to submit proof that your dependent is disabled. Your unmarried dependent child(ren) up to age 25 is eligible for medical and/or dental coverage if he/she wholly depends on you for support.

3. Complete Section IV if you, your spouse and/or dependent(s) have other insurance and/or Medicare coverage.
4. Complete Section V by checking the appropriate box to decline or elect participation in the flexible spending accounts. If you elect to make spending account contributions, indicate the amount(s) you want to contribute each pay period to one or both of the spending accounts.
5. Complete Section VI by checking the appropriate box for pre-tax or after-tax payroll deductions. Read the authorization for payroll deductions and disclosure of information **and sign and date the form.**

**PLEASE USE A BALLPOINT PEN TO COMPLETE THIS FORM. PRESS FIRMLY TO GO THROUGH ALL COPIES.
PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM.**

I. EMPLOYEE INFORMATION

GROUP NUMBER:
3153744: CIGNA
4011-00: KAISER PERMANENTE

EMPLOYER:
UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH

EMPLOYEE NAME (Last, First, MI)

HOME ADDRESS	STREET ADDRESS	CITY	STATE	ZIP
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HOME PHONE	WORK PHONE	SOCIAL SECURITY NUMBER
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Marital Status (circle status) Single Married Divorced Legally Separated Widowed Common Law/Domestic Partner*
*If you elect "common law/domestic partner" for your marital status, you will need to submit appropriate documentation to Human Resources.

II. SMART CHOICES PLAN OPTIONS FOR 2007

MEDICAL OPTIONS FOR 2007	DESCRIPTION
<input type="checkbox"/> OPTION I	CIGNA – HMO (participants must reside in the Colorado or Mid-Atlantic service area)
<input type="checkbox"/> OPTION II	CIGNA - PPO 90% in-network or 80% non-network (\$200 per person/\$400 family maximum deductible applies)
<input type="checkbox"/> OPTION III	CIGNA - HDHP 100% in-network or 80% non-network after \$2,800 per person/\$5,600 family maximum deductible applies Individual HSA: \$2,800 per year maximum (\$107.69 per pay period maximum) If age 55-65, \$3,600 per year maximum (\$138.46 per pay period maximum) Individual +1 or Family HSA: \$5,600 per year maximum (\$215.38 per pay period maximum) If age 55-65, \$6,400 per year maximum (\$246.15 per pay period maximum) I elect to participate in Health Savings Account for 2007. My total amount is \$ _____ PER YEAR. I elect to contribute \$ _____ PER PAY PERIOD. Participation is optional.
<input type="checkbox"/> OPTION IV	Kaiser Permanente - HMO (Mid-Atlantic participants must complete an additional Mid-Atlantic application)
<input type="checkbox"/> NO MEDICAL COVERAGE	If you elect "no coverage", is insurance provided by your spouse who works for UCAR? <input type="checkbox"/> Yes <input type="checkbox"/> No
DENTAL OPTIONS FOR 2007	DESCRIPTION
<input type="checkbox"/> DENTAL	CIGNA
<input type="checkbox"/> NO DENTAL COVERAGE	If you elect "no coverage", is insurance provided by your spouse who works for UCAR? <input type="checkbox"/> Yes <input type="checkbox"/> No

THE COVERAGE INDICATED ABOVE IS FOR: Individual Individual Plus One Individual Plus Family

III. MEMBER INFORMATION

You are required to fill out the information below if you are changing coverage or adding or deleting coverage for dependents. If dependent coverage has changed since last year, please fill out the section below for yourself and all of your dependents. This includes choosing CIGNA HealthCare or Kaiser Permanente for the first time.

Coverage For:	Name (Last, First, MI)	Date of Birth	Sex (M/F)	Social Security Number	Student Age 24-25 (Y/N)	Disabled (Y/N)	COMPLETE THESE TWO COLUMNS ONLY IF YOU CHOOSE OPTION I	
							Primary Care Provider ID Number	Is This Your Current Provider? (Y/N)
Employee								
Spouse								
Child								
Child								
Child								

If you have additional dependents, attach an additional sheet of paper with the requested information, and c ck here:

IV. MEDICARE AND OTHER INSURANCE COVERAGE

Are you or any of your dependents currently receiving Medicare benefits? Yes No
 Do you or any of your dependents have coverage under any other medical or dental plan? Yes No
 If you answered "Yes" to either question above, please provide the following information for each person covered.

Name of Person Covered by Medicare or Other Insurance	Employer Providing Coverage	Employer's Telephone Number	Is Coverage Individual or Family?	Insurance Company Name

V. FLEXIBLE SPENDING ACCOUNTS ELECTION

- I do not want to participate in either Flexible Spending account.
- I elect to participate in the **HEALTH CARE SPENDING ACCOUNT** for 2007.
 My total amount is \$ _____ PER YEAR. I elect to contribute \$ _____ PER PAY PERIOD.
(minimum annual amount is: \$130, maximum annual amount is: \$10,000)
- I elect to participate in the **DEPENDENT CARE SPENDING ACCOUNT** for 2007.
 My total amount is \$ _____ PER YEAR. I elect to contribute \$ _____ PER PAY PERIOD.
(minimum annual amount is: \$130, maximum annual amount is: \$5,000)

IMPORTANT: You need to carefully plan the amount you contribute to your flexible spending account(s). You are reimbursed for eligible expenses incurred during 2006 *only*. If you do not incur enough eligible expenses during the year to use the full amount in your account(s), the remaining balance will be forfeited in accordance with federal law. The amount you elect to contribute cannot be changed unless you experience a qualified change in family status.

VI. AUTHORIZATION FOR PAYROLL DEDUCTIONS AND TO OBTAIN AND DISCLOSE INFORMATION

By signing below, I authorize UCAR to make payroll deductions each pay period for the medical/dental option and any spending account or savings account contributions I have elected on a **pre-tax basis**. *Other options include:*

Make my payroll deduction for medical/dental contribution on an: After-Tax Basis
 Make my payroll deduction(s) for spending account(s) contribution(s) on an: After-Tax Basis

I understand that I cannot change my medical/dental selection until the next annual enrollment period or unless I experience a qualifying change in family status. I also understand that I cannot change the amount of my contributions to the Health Care and/or Dependent Care Spending Account(s) or Health Savings Account unless my family status changes.

I request coverage for myself and any eligible dependents as listed on this form. If I am a UCAR employee, I authorize UCAR to reduce my pay each pay period for the pre-tax or after-tax cost of the benefit option I have elected to make to one or both of the spending accounts or the Health Savings Account.

I give "you" permission to give CIGNA or Kaiser Permanents (KP) any information about me and the listed dependents necessary for determining eligibility for insurance and benefits detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. The word "you" refers to any organization or person that has records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This includes my employer, any provider of health care, insurance companies from whom I have purchased insurance and other insurance support agencies. This information may also be given to CIGNA or KP and to their legal representatives and reinsurers.

I give CIGNA or KP, their legal representatives, and any person or organization administering claims on behalf of CIGNA or KP, permission to release to my employer or representative a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group health plan or for the purpose of conducting an audit of CIGNA's or KP's operations or services. The summary of claims may identify the person for whom services were provided, the nature of the condition, the date and nature of services rendered, the provider of the services and the amount of the claim.

If I have selected coverage under Option II, I also authorize payment of medical benefits to providers of these plans as necessary. In order to be covered by the CIGNA HMO, I understand and agree that with the exception of life-threatening emergency procedures, all services must be performed either by a Participating Provider or authorized by prior written referral. If performed by a provider outside the network, benefits could be reduced or eliminated. I understand and agree that with the exception of emergency procedures, all services, in order to be covered by the Kaiser Permanente HMO, must be performed by a Kaiser Permanente provider at a Kaiser Permanente facility. If performed by a provider outside of Kaiser Permanente, benefits are eliminated. I will pay any required copayments directly to the providers of health care.

I agree to be bound by all terms of the plan under which I am applying for coverage. This authorization applies for as long as I have coverage under the plan. I agree that a copy of this authorization shall be as valid as the original.

I certify that, to the best of my knowledge, the information shown on this enrollment form is correct.

I understand that as part of my membership, including spouse and dependents if applicable, the health plan Service Agreement requires that any claim for money damages asserted by a member or the member's heirs or personal representatives must be submitted to binding arbitration instead of a court trial.

SIGNATURE OF EMPLOYEE	DATE SIGNED
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TO BE COMPLETED BY UCAR ONLY

EMPLOYEE I.D.	BRANCH CODE	APPT. CODE	FTE	ANNUAL SALARY
HEALTH CARE EFFECTIVE DATE	FSA EFFECTIVE DATE	HSA EFFECTIVE DATE	ENTERED BY	DATE