

Leslie & Associates Benefit Alliance Enrollment Form for Kelly Services Employees

Mail to: 17304 Preston Rd. Suite 1320 Dallas, TX 75252

Member Name _____ Social Security Number _____ / _____ / _____ Sex _____ Hire Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Telephone _____ Age _____ Birth Date _____ Birth State _____ Occupation _____
Area Code

Email Address _____ Cell Phone _____ Latest Assignment Date _____
Area Code

Spouse Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #1 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #2 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #3 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

GROUP TERM LIFE INSURANCE PLAN

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Family
Employee Coverage	<input type="checkbox"/> <i>Smoker</i> <input type="checkbox"/> <i>Non-Smoker</i>	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000	Monthly Premium _____
Beneficiary Name _____		Beneficiary Relationship _____	
Spouse Coverage	<input type="checkbox"/> <i>Smoker</i> <input type="checkbox"/> <i>Non-Smoker</i>	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	Monthly Premium _____
Beneficiary Name _____		Beneficiary Relationship _____	
Dependent Children Coverage	<input type="checkbox"/> \$5,000 / at \$1.25 per month <input type="checkbox"/> \$7,500 / at \$1.75 per month <input type="checkbox"/> \$10,000 / at \$2.25 pr month	Monthly Premium _____	

SHORT TERM DISABILITY INCOME PLAN

Weekly Kelly Salary \$ _____ X 50% = _____ = Maximum Weekly Benefit *(round down to nearest \$50 increment)* **Monthly Premium** _____

\$100 \$150 \$200 \$250 \$300 \$350 \$400 \$450 \$500 \$550 \$600 Other _____

I understand and agree that no short-term disability benefits will be payable for any disability which is caused by, contributed to by, or resulting from a Pre-Existing Condition. A Pre-Existing Condition is any injury, disease, sickness, pregnancy or mental disorder for which you visited or consulted a physician, hospital or medical facility or took clinical tests or received treatment. This includes (but is not limited to) taking pills, injections or other medications.

GROUP DENTAL PLAN - Area 3

	Plan 1 (Low)	Plan 2 (High)	
Employee Only	<input type="checkbox"/> \$ 39.06 monthly	<input type="checkbox"/> \$ 60.01 monthly	
Employee & Spouse	<input type="checkbox"/> \$ 65.80 monthly	<input type="checkbox"/> \$ 118.16 monthly	
Employee & Children	<input type="checkbox"/> \$ 82.03 monthly	<input type="checkbox"/> \$ 121.75 monthly	
Employee & Family	<input type="checkbox"/> \$ 114.30 monthly	<input type="checkbox"/> \$ 179.87 monthly	Monthly Premium _____

EYEMED VISION CARE PLAN

<input type="checkbox"/> Employee Only	\$ 8.00 per month	
<input type="checkbox"/> Employee & One <i>(Spouse or Child)</i>	\$ 14.50 per month	
<input type="checkbox"/> Employee & Family	\$ 21.50 per month	Monthly Premium _____

GROUP ACCIDENT INSURANCE PLAN

<input type="checkbox"/> Employee Only	\$ 21.19 per month	
<input type="checkbox"/> Employee & Spouse	\$ 28.12 per month	
<input type="checkbox"/> Employee & Dependent Child(ren)	\$ 29.86 per month	
<input type="checkbox"/> Employee & Family	\$ 36.79 per month	Monthly Premium _____

GROUP LIMITED ACCIDENT & SICKNESS - ENHANCED PLANS (include separate Rx & co-pay provision)

	<i>Tier 3</i>	<i>Tier 4</i>	
Employee Only	<input type="checkbox"/> \$ 154.00 per month	<input type="checkbox"/> \$ 280.00 per month	Monthly Premium _____
Employee & Spouse	<input type="checkbox"/> \$ 319.00 per month	<input type="checkbox"/> \$ 586.00 per month	
Employee & Child(ren)	<input type="checkbox"/> \$ 257.00 per month	<input type="checkbox"/> \$ 471.00 per month	
Employee & Family	<input type="checkbox"/> \$ 428.00 per month	<input type="checkbox"/> \$ 787.00 per month	

GROUP LIMITED ACCIDENT & SICKNESS - STANDARD PLANS (no Rx & no co-pay provision)

	<i>Tier 1</i>	<i>Tier 2</i>	
Employee Only	<input type="checkbox"/> \$ 82.00 per month	<input type="checkbox"/> \$ 103.00 per month	Monthly Premium _____
Employee & Spouse	<input type="checkbox"/> \$ 169.00 per month	<input type="checkbox"/> \$ 196.00 per month	
Employee & Child(ren)	<input type="checkbox"/> \$ 143.00 per month	<input type="checkbox"/> \$ 165.00 per month	
Employee & Family	<input type="checkbox"/> \$ 232.00 per month	<input type="checkbox"/> \$ 257.00 per month	

I have read the Group Limited Accident & Sickness Plan enrollment materials and accept the terms and conditions outlined in them. I understand no benefits will be paid for any medical condition or illness due to a pre-existing condition for up to 6 months for myself or my dependents. The 6 month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A pre-existing condition is any disease, illness, sickness, or injury which was diagnosed or treated by a Doctor or required taking prescribed drugs or medicines within the 6 month period immediately preceding the effective date of coverage. The Limited Accident & Sickness Plan is group insurance underwritten by ACE American Insurance Company and the benefits will vary depending on the plan selected. I understand the policy is subject to exclusions, limitations. I understand it does NOT provide Major Medical or Comprehensive Medical coverage. The limitations are disclosed in the enrollment materials, policy and certificate which are made available at the time of enrollment.

Yes No

OPTIONAL STAND-ALONE ACTIVASCRIPTS PRESCRIPTION DRUG CO-PAY PLAN

<input type="checkbox"/> Employee Only	\$ 17.73 per month	Monthly Premium _____
<input type="checkbox"/> Employee & Spouse	\$ 35.47 per month	
<input type="checkbox"/> Employee & Children	\$ 26.76 per month	
<input type="checkbox"/> Employee & Family	\$ 44.34 per month	

I have enclosed a check or money order payable to Special Insurance Services, Inc., the authorized administrator of the Leslie and Associates Benefit Alliance Trust for Kelly Services Employees, for the first monthly premium due for the benefits I have selected. I understand I will incur a one-time enrollment fee of \$20.00. In addition, I agree to a monthly service charge of \$2.00 if I elect the Bank Draft Authorization method of premium payments or \$3.00 per month if I am billed directly by Special Insurance Services, Inc. (SIS).

Sub-Total for All Premiums _____

Add Enrollment Fee + \$20.00

Add Administrative Fee + _____
(\$2.00 / Bank Draft or \$3.00 / Direct Bill)

CHOOSE YOUR FUTURE BILLING PREFERENCE

Monthly Direct Billing Bank Draft Authorization

*Complete and return the "Bank Draft Authorization Form"
 Attach "voided" check or copy of voided check*

INITIAL PAYMENT MUST BE ENCLOSED

(MAKE ALL PAYMENTS PAYABLE TO SPECIAL INSURANCE SERVICES, INC.)

Mail to: Leslie & Associates Benefit Alliance ♦ 17304 Preston Rd. Suite 1320 ♦ Dallas, TX 75252

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the Leslie and Associates Benefit Alliance Trust. The trust is not the insurance company and has no responsibility for this insurance except to hold the master policy. This statement does not apply to the Limited Accident & Sickness Plans or Group Accident Plans underwritten by ACE American Insurance Company.

To the best of my knowledge and belief, all statements and answers are true and complete. They are offered as the basis for any insurance issued. Any person who with intent to defraud or knowingly submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud. This enrollment form shall not bind the insurance company and I understand that no insurance will be in effect until my application is approved, certificate issued and the necessary premium is paid. It is understood and agreed that coverage will not become effective unless I am actively at work (not on a leave of absence) on the date of enrollment and the effective date of my coverage.

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 related to a claim was provided by the applicant.

Date _____ Signature of Employee _____ Daytime Phone (_____) _____ Kelly Branch Number _____