Leslie & Associates Benefit Alliance Enrollment Form for Kelly Services Employees

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

Member Name ______ (First) ______ (MI) ______ (Last) Social Security Number ____/____/____ Sex ______ Assignment Date ______

Address ______ City ______ State ______ Zip ______

Telephone ______ (Area Code) Age ______ Birth Date ______ Birth State ______ Occupation ______

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 PLAN

☐ **Employee Only** ☐ **Employee & Spouse** ☐ **Employee & Children** ☐ **Family**

Employee Coverage ☐ *Smoker* ☐ *Non-Smoker* ☐ $50,000 ☐ $75,000 ☐ $100,000 **Monthly Premium** ______

Beneficiary Name ______ Beneficiary Relationship ______

Spouse Coverage ☐ *Smoker* ☐ *Non-Smoker* ☐ $25,000 ☐ $50,000 **Monthly Premium** ______

Beneficiary Name ______ Beneficiary Relationship ______

Dependent Children Coverage ☐ $5,000 / at $1.25 per month ☐ $7,500 / at $1.75 per month ☐ $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 treatement. This includes (but is not limited to) taking pills, injections or other medications.

GROUP DENTAL PLAN - Area 2

	Plan 1 (Low)	***Plan 2 (High)***
Employee Only	☐ $ 31.93 monthly	☐ $ 49.05 monthly
Employee & Spouse	☐ $ 53.77 monthly	☐ $ 96.57 monthly
Employee & Children	☐ $ 67.04 monthly	☐ $ 99.51 monthly
Employee & Family	☐ $ 93.42 monthly	☐ $147.01 monthly

Monthly Premium ______

EYEMED VISION CARE PLAN

☐ Employee Only	$ 8.00 per month
☐ Employee & One *(Spouse or Child)*	$ 14.50 per month
☐ Employee & Family	$ 21.50 per month

Monthly Premium ______

GROUP ACCIDENT INSURANCE PLAN

☐ Employee Only	$ 21.19 per month
☐ Employee & Spouse	$ 28.12 per month
☐ Employee & Dependent Child(ren)	$ 29.86 per month
☐ Employee & Family	$ 36.79 per month

Monthly Premium ______

CRITICAL ILLNESS PLAN

****Must include separate completed Continental American Insurance Company application #CAIC01-SI-KS for critical illness***

Employee Coverage ☐ *Smoker* ☐ *Non-Smoker* Insurance Amount ______ **Monthly Premium** ______

Spouse Coverage ☐ *Smoker* ☐ *Non-Smoker* Insurance Amount ______ **Monthly Premium** ______

See Reverse Side

GROUP SUPPLEMENTAL HOSPITAL INDEMNITY PLAN - BASIC PLAN

Employee Only	☐ $ 82.53 per month
Employee & Spouse	☐ $ 169.04 per month
Employee & Children	☐ $ 143.16 per month
Employee & Family	☐ $ 232.68 per month

Monthly Premium ______________

Do you understand and agree that no benefits are payable for injury or loss during the 12 months after the effective date of coverage or from 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less, which is caused by, contributed to by, or resulting from a pre-existing condition? A pre-existing condition means within the 12-month period prior to the effective date of the certificate and attached riders, as applicable; a condition for which medical advice, diagnosis, care or treatment was recommended or received. ☐ Yes ☐ No

GROUP SUPPLEMENTAL HOSPITAL INDEMNITY PLAN - PREMIER PLAN

Employee Only	☐ $ 103.54 per month
Employee & Spouse	☐ $ 196.01 per month
Employee & Children	☐ $ 165.00 per month
Employee & Family	☐ $ 257.47 per month

Monthly Premium ______________

Do you understand and agree that no benefits are payable for injury or loss during the 12 months after the effective date of coverage or from 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less, which is caused by, contributed to by, or resulting from a pre-existing condition? A pre-existing condition means within the 12-month period prior to the effective date of the certificate and attached riders, as applicable; a condition for which medical advice, diagnosis, care or treatment was recommended or received. ☐ Yes ☐ No

ACTIVASCRIPS PRESCRIPTION DRUG CO-PAY PLAN

☐ Employee Only	$ 17.73 per month
☐ Employee & Spouse	$ 35.47 per month
☐ Employee & Children	$ 26.76 per month
☐ Employee & Family	$ 44.34 per month

Monthly Premium ______________

MID MED - GROUP LIMITED MEDICAL INSURANCE

	Level I	*Level 2*
Employee Only	☐ $ 153.75 per month	☐ $ 280.73 per month
Employee Plus One	☐ $ 279.21 per month	☐ $ 516.73 per month
Employee & Family	☐ $ 377.29 per month	☐ $ 702.63 per month

Monthly Premium ______________

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 provider within the 6 month period immediately preceding the effective date of coverage. A pregnancy that exists on the day before the effective date of coverage will be considered a pre-existing condition. The Med-Med Plan is group insurance underwritten by Continental American Insurance Company and the benefits will vary depending on the plan selected. I understand the policy is subject to exclusions, limitations and a reduced annual and life time limit - it is not designated as a substitute for basic health insurance or major medical coverage. The limitations are disclosed in the enrollment materials, policy and certificate which are made available at the time of enrollment. I acknowledge I have read this notice and understand coverage cannot be processed unless this form is signed and dated here:

Required Signature for Mid Med Plan: ______________________ Date: __________

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.

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.

Date __________ Signature of Employee ______________________ Daytime Phone (______) __________ Kelly Branch Number __________