



CenturyLink™

2010 ANNUAL ENROLLMENT ELECTION FORM - LTD

*If you reside in one of the following states and elect the PPO medical plan, you will be enrolled in the Highmark PPO plan: Indiana, Michigan, Nevada, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee or Virginia. You will need to complete and return this form in order to be enrolled in 2010 healthcare benefits.

Form header with fields: EFFECTIVE DATE: 01/01/2010, For questions, call CenturyLink Employee Resource Center at 1-888-722-4372, Social Security Number, Last Name, First Name, M Initial, Personnel Number, Date of Hire, Job Title, Date of Birth, Home Phone Number, Mailing Address, City, ST, Zip

Is your spouse/domestic partner eligible to elect healthcare coverage through their employer? Yes (*) ___ No ___ Not Married ___
(* If YES, a working spouse surcharge will apply.
Is your spouse/domestic partner a CenturyLink employee or retiree? Yes ___ No ___ Not Married ___ (Double coverage is not allowed)
If Yes, please list their first and last name and social security number:
Are you & all members in your household NON-USERS of tobacco products? Yes ___ No ___ (* If YES, a smoker credit will apply.
If "No", are all tobacco users in your household enrolled in a company recognized tobacco cessation program? Yes ___ No ___

Table with 8 columns: ADD (Check box), REMOVE (Check box), LIST DEPENDENT/S: First, M Initial & Last Name/s, GENDER M/F, RELATIONSHIP TO EMPLOYEE, STATUS, FULL SOCIAL SECURITY NO., DATE OF BIRTH: Mo, Day, Yr, *FULL TIME STUDENT: Yes, No

*(Full-time Student) - For dependent/s between the ages of 19 and 25, a current full-time Student Verification form must be on file.

Table with 6 columns: MEDICAL PLAN (includes Rx plan), COVERAGE LEVEL FOR MEDICAL, DENTAL PLAN, COVERAGE LEVEL FOR DENTAL, VISION PLAN, COVERAGE LEVEL FOR VISION

VOLUNTARY SUPPLEMENTAL LIFE PLAN: (Employee paid plan)
 Keep Current Coverage
WAIVE
 Employee coverage Child coverage
 Spouse coverage

AUTHORIZATION: I have received and read the printed material describing my benefit plan options. I understand that the plan elections I have made are binding for the calendar year and that I will not be able to change my election until the next annual enrollment period, or within 31 days of a qualified status change. A request in writing is required to remove, update or waive my plans. The request should be sent to CenturyLink Employee Resource Center. If I am required to pay monthly health care premiums, I understand that I will be receive monthly invoices from A & I Benefit Plan Administrators, (1220 SW Morrison #300 Portland, OR 97205-2222) prior to the first of each month for which I wish to have coverage. I understand that failure to make payments by the first of each month for that month's coverage will result in termination of my benefits. Benefits will not be reinstated. I authorize any provider of health services to provide, upon request, any information concerning the health, condition or treatment of any covered person whenever such information is considered necessary with respect to the delivery of medical care, the proper disposition of claims submitted for payment, medical management activities or in fulfillment of obligations imposed by State or Federal Law. I certify that the information supplied above is true to the best of my knowledge. I understand it is a crime to fill out this form with facts I know are false or to leave out facts that are important. I understand that any falsification, misrepresentation, misleading statements or omission may be cause for immediate termination regardless of when or how discovered.

SIGNATURE: _____ DATE: _____

Please return original to the CenturyLink Employee Resource Center, KSOPKR0101, 5454 W. 110th Street, Overland Park, KS 66211