



CenturyLink™

**LEGACY EQ**  
COBRA-EQForm10

**2010 ANNUAL ENROLLMENT ELECTION FORM  
COBRA PARTICIPANT**

<b>EFFECTIVE DATE: 01/01/2010</b>		<b>KEEP A COPY FOR YOUR RECORDS</b>	
<b>FOR QUESTIONS, CALL THE EMPLOYEE RESOURCE CENTER AT 1-888-722-4372 OR A&amp;I BENEFIT PLAN ADMINISTRATORS AT 1-800-547-4457</b>			
Last Name		First Name	Middle Initial
Social Security Number		Date of Birth	
Mailing Address			
City		State	Zip
Home Telephone Number w/Area Code ( )		Alternate Telephone Number w/Area Code ( )	

**NOTE: If you reside in one of the following states and elect a PPO medical plan, you will be eligible to enroll in the Highmark PPO plan:**  
**-Indiana -Michigan -Nevada -New Jersey -North Carolina -Ohio -Pennsylvania -South Carolina -Tennessee -Virginia**

**\*You will need to complete and return this form  
NO LATER THAN MONDAY, NOVEMBER 23, 2009**

**in order to be enrolled in 2010 healthcare benefits. (address is listed below)**

**2010 HEALTHCARE PLANS**

<b>Medical Coverage</b>	<input type="checkbox"/> UHC PPO	<input type="checkbox"/> Highmark PPO <small>(SEE NOTE ABOVE)</small>	<input type="checkbox"/> UHC CDHP	<input type="checkbox"/> Waive Medical Coverage
<b>Dental Coverage</b>	<input type="checkbox"/> Delta Dental Basic	<input type="checkbox"/> Delta Dental Enhanced	<input type="checkbox"/> Waive Dental Coverage	
<b>Vision Coverage</b>	<input type="checkbox"/> Vision Service Plan	<input type="checkbox"/> Waive Vision Coverage		

**2010 COVERAGE LEVELS**

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child/ren	<input type="checkbox"/> Employee & Family
<input type="checkbox"/> Employee & Domestic Partner	<input type="checkbox"/> Employee & Domestic Partner & Child/ren	<input type="checkbox"/> Spouse Only	<input type="checkbox"/> Spouse & Child/ren
<input type="checkbox"/> Domestic Partner Only	<input type="checkbox"/> Domestic Partner & Child/ren	<input type="checkbox"/> Children Only	

**2010 DEPENDENT INFORMATION** To add, remove or update dependents, complete the section below.

ADD	REMOVE	UPDATE	LIST DEPENDENT/S (FIRST, M INITIAL AND LAST NAME/S)  <i>(If you have more than four dependents to list below, please fill out another form in its entirety to include your remaining dependents)</i>	GENDER: M/F	RELATIONSHIP CODE: 1-Spouse 2-Child 6-Step Child 13-Domestic Partner (Certification Required) 91-Grandchild 92-Niece/Nephew	FULL SOCIAL SECURITY NUMBER:  <i>(NOT required for newborns; temporary ss# will be assigned)</i>	DATE OF BIRTH:			*FULL TIME STUDENT (Age 19-25)	
							Mo.	Day	Yr.	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.

**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 annual enrollment period, or within 31 days of a qualified status change. I further understand that I have the option to waive my existing plans at any point during the year. A request in writing is required to remove, update or waive my plans. The request should be sent to A&I Benefit Plan Administrators. I understand I will receive monthly invoices from A&I Benefit Plan Administrators for payments due on the first day of the month in which I am purchasing coverage. Payment must be received by the end of the month for which coverage is purchased. If I fail to make timely payments, I understand that COBRA benefits will terminate on the last day of the month for which payment was made. Benefits may 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 claim 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 that any falsification, misrepresentation, misleading statements or omission may be cause for immediate termination regardless of when or how discovered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return original to A&I Benefit Plan Administrators, Attn: CenturyLink Enrollment, 1220 SW Morrison St. #300, Portland, OR, 97205-2222**