

HEALTH CARE ENROLLMENT AND CHANGE FORM

New Hire Enrollment: If you are a new hire or re-hire, you must return this **2-page** form within **30 days** of your eligibility date. If you do not wish to enroll in the health coverage, select Waive Coverage.

☐ New Hire Enrollment ☐ Re-Hire Enrollment ☐ Waive Coverage Date of Hire (Re-hire): _____

Change Requests: Select the change request(s) that apply and include the effective date. If you are enrolling yourself or your spouse, page 2 of this form is also required.

☐ Add Self ☐ Add Family Member(s) ☐ Cancel Self ☐ Cancel Family Member(s)
☐ Change Coverage ☐ Report a change in spouse's access to other employer medical coverage Effective Date of Change: _____

Instructions:

If you are **enrolling** family members, **ALL** information below must be completed for each person. The entire family must have the same coverage (medical, prescription drug, vision and/or dental).

You must provide a copy of your marriage certificate for a spouse and a birth certificate for each child requesting coverage.

If you are **cancelling** family members, only the social security number, name and date of birth are required below. Only list those family members to be cancelled.

EMPLOYEE INFORMATION

Social Security #:	First Name:	Last Name:	Plant #:
Email Address:	Date of Birth:		
Home Phone:	Cell Phone:	Marital Status: ☐ Single (never married) ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

COVERAGE INFORMATION

Individuals to be enrolled (skip if cancelling coverage): ☐ Employee Only ☐ Employee + Family Member(s)

Coverage (select one): ☐ Medical, Dental, Prescription Drug and Vision Coverage ☐ Medical, Prescription Drug and Vision Coverage (excludes Dental) ☐ Dental Coverage only

FAMILY MEMBER INFORMATION

Spouse's Social Security #	Spouse's First Name	MI	Spouse's Last Name	Date of Birth	Gender (M / F)	Employed	Employer offers medical coverage	Other medical coverage elected
						☐ Yes ☐ No	☐ Yes ☐ No*	☐ Yes** ☐ No

* If a spouse's employer does not offer coverage, a letter from the other employer verifying medical benefits are not offered to the spouse must be provided to waive the working spouse surcharge.

** If other coverage is elected, the other employer's plan is the spouse's primary insurance. Crown's coverage is secondary. Secondary does not include prescription drug coverage.

Child Dependent's Social Security #	Child's First Name	MI	Child's Last Name	Date of Birth	Gender (M / F)	Relationship to Employee	Has other medical coverage
1							☐ Yes* ☐ No
2							☐ Yes* ☐ No
3							☐ Yes* ☐ No
4							☐ Yes* ☐ No

* If enrolled in two medical plans, the birthday rule applies (parent with the earlier birth date and month determines the primary payer). If Crown is secondary, there is no prescription drug coverage

AUTHORIZATION

This form must be completed by each employee in order to enroll the employee and any eligible family members for coverage. All information must be answered in full. Family members will not be covered for services prior to the date of their enrollment. Family members are subject to the eligibility and Maintenance of Benefits requirements for the Company.

I hereby certify the information contained on this form is true and correct. I understand any case of fraud discovered will be pursued by the Company, and may result in my termination. I authorize the Company to make payroll deductions in an amount equal to the contribution required for this coverage. I understand that if my spouse's access to other group medical insurance changes, it is my responsibility to notify Human Resources within 30 days of such change.

I understand that Crown Cork & Seal Company, Inc. reserves the right to modify, suspend, change, or terminate the Crown Cork & Seal Company, Inc. Group Welfare Plan at any time.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

MEDICAL PROGRAM TOBACCO USE AFFIDAVIT



INSTRUCTIONS: This form must be completed if an employee and/or spouse is requesting to enroll or re-enroll in the Crown Medical Program. You will be required to re-certify your and, if applicable, your spouse's tobacco use during each annual benefits open enrollment. If your tobacco use status changes during the year, you may submit a revised affidavit at any time. You must be tobacco-free for the preceding six month period to certify as a non-tobacco user. Any change to your cost will become effective going forward once a revised affidavit is received.

An employee or spouse who is a tobacco user must pay a surcharge to be enrolled in the Crown Medical Program. If you used a tobacco product an average of four or more times per week, you are considered a "tobacco user". Tobacco products include cigarettes, cigars, cigarillos, pipes, chewing tobacco, snuff, dip, loose tobacco smoked via pipe or hookah, smokeless or electronic devices, and any other form of tobacco or nicotine products regardless of method of use.

EMPLOYEE INFORMATION

First Name:	Last Name:	
Social Security #:	Plant #:	Date of Birth:

EMPLOYEE CERTIFICATION

Select one:

- ☐ I have been a tobacco user in the past 6 months (*surcharge applies*)
- ☐ I have **NOT** been a tobacco user in the past 6 months

SPOUSE CERTIFICATION (REQUIRED IF YOUR SPOUSE IS ENROLLED IN THE CROWN MEDICAL PROGRAM)

Spouse's First Name:	Spouse's Last Name:	Spouse's Date of Birth:
Select one:		
☐ My spouse has been a tobacco user in the past 6 months (<i>surcharge applies</i>)		
☐ My spouse has NOT been a tobacco user in the past 6 months		

AUTHORIZATION

I hereby certify I have read this form and my responses are true and correct. I understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in retroactive payroll contribution adjustments, loss of medical coverage, and/or disciplinary action up to and including termination of employment.

I understand that Crown Cork & Seal Company, Inc. reserves the right to modify, suspend, change, or terminate the Crown Cork & Seal Company, Inc. Group Welfare Plan, including the Crown Medical Program, at any time.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

If it is unreasonably difficult due to a medical condition for you (or your spouse) to become tobacco-free (or if it is medically inadvisable for you to attempt to become tobacco-free), we will make available a reasonable alternative standard so that you may avoid the tobacco surcharge. Please contact the Corporate Insurance Department for more information.