CORESOURCE
A Trustmark Company

Enrollment Form

AeroVironment
CS Group #: AE0000

INSTRUCTIONS: *White portion to be completed by the employee. Shaded portion to be completed by the Employer. Print clearly in dark ink, sign the form, and return as instructed.*

Name of Employer	Group #	Account #	Dept./Location Code	Date of Hire	Effective Date of Coverage
				/ /	/ /

❍New Enrollment ❍Reinstatement ❍Addition of Dependent(s)	❍Regular Enrollee* **See back of form for definitions.* ❍Late Enrollee* ❍Special Enrollee* Reason #: ________________________	Salary *(Supply only if there are salary based benefits)*

Employee Information.

Employee Name (last, first, middle initial)	❍ Female ❍ Male	Date of Birth / /	Social Security Number	Employee ID#

Employee Address (street address, city, state, zip code)	Telephone Home ( ) Work ( )

Marital Status*	Job Title or Occupation	Employment Status ❍Active Full-Time ❍COBRA

MEDICAL PLAN OPTION: ❍ PPO Plan ❍ EPO Plan

Level of Coverage								
	Medical:	❍Employee Only	❍EE + Spouse	❍EE + 1 Child	❍EE + 2 or more Children	❍EE + Spouse +1 Child	❍Family	❍Decline
	Dental:	❍Employee Only	❍EE + Spouse	❍EE + 1 Child	❍EE + 2 or more Children	❍EE + Spouse +1 Child	❍Family	❍Decline

Coverage Information. *Please complete this section for yourself and each of your dependents. If you have additional dependents, attach a second form or a separate page.*

Employee's Coverage Selection {Medical ❍Yes ❍No**} {Dental** ❍Yes ❍No**}** If no, list reason:	Do you have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /

Dependent's Full Name (last, first, middle initial)				Dependent's Coverage Selection **{Medical** ❍Yes ❍No**} {Dental** ❍Yes ❍No**}** If no, list reason:
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /
Dependent's Full Name (last, first, middle initial)				Dependent's Coverage Selection **{Medical** ❍Yes ❍No**} {Dental** ❍Yes ❍No**}** If no, list reason:
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /
Dependent's Full Name (last, first, middle initial)				Dependent's Coverage Selection **{Medical** ❍Yes ❍No**} {Dental** ❍Yes ❍No**}** If no, list reason:
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /
Dependent's Full Name (last, first, middle initial)				Dependent's Coverage Selection **{Medical** ❍Yes ❍No**} {Dental** ❍Yes ❍No**}** If no, list reason:
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /

Coverage Information. (Continued) *Please complete this section for yourself and each of your dependents. If you have additional dependents, attach a second form or a separate page.*				
Dependent's Full Name (last, first, middle initial)			Dependent's Coverage Selection **{Medical** ❍Yes ❍No**}** **{Dental** ❍Yes ❍No**}** If no, list reason:	
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /
Dependent's Full Name (last, first, middle initial)			Dependent's Coverage Selection **{Medical** ❍Yes ❍No**}** **{Dental** ❍Yes ❍No**}** If no, list reason:	
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /
Dependent's Full Name (last, first, middle initial)			Dependent's Coverage Selection **{Medical** ❍Yes ❍No**}** **{Dental** ❍Yes ❍No**}** If no, list reason:	
Relationship to Employee	SSN	Gender (F/M)	Date of Birth / /	Does this dependent have other insurance coverage or Medicare? ❍Yes ❍No If yes, name of insurer: Effective Date: / /

READ THE REVERSE SIDE AND THEN SIGN AND DATE BELOW:

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I have read and understand the information provided on the back on this form. I authorize the required deductions for my share of coverage from my wages.

Employee's Signature	Date Signed	Signature of Benefits Administrator	Date Signed

Declination of Medical Coverage

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan or policy, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are declining enrollment for any other reason, or if you fail to complete this form, you may be subject to certain plan or policy provisions including but not limited to enrollment permitted only during the annual enrollment period and an 18 month pre-existing condition limitation or exclusion period upon enrollment.

Pre-existing Condition Limitation

This Pre-existing Condition Limitation notice is being issued to you pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This group health plan or policy may contain a pre-existing condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). If your group health plan or policy has a Pre-existing Limitation, the exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan or policy is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certification(s) of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). (If necessary, we will assist you in obtaining a certificate from any of these entities).

Fraud Warning Statement

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

Instructions for * fields on the front side of this form

Late Enrollee* (Medical Coverage Only)	A late enrollee is an individual who is enrolling for Medical coverage after the first available opportunity for one of these reasons: Reason #1: This individual initially declined this coverage for any reason other than s/he already had other coverage. Reason #2: This individual failed to enroll within 31 days of a special enrollment event (i.e. birth, marriage, etc.).
Regular Enrollee*	A regular enrollee is a new employee (this may or may not include dependents) just hired and enrolling into the plan or policy at the first available opportunity (within 31 days of the date of hire).
Special Enrollee* (Medical Coverage Only)	A special enrollee is an individual who is enrolling for Medical coverage after the first available opportunity for one of these reasons: Reason #1: This individual declined this coverage at the first available opportunity because s/he already had other coverage and has now lost that other coverage. Reason #2 (a, b, c): This individual gained a dependent through (a) marriage (b) birth (c) adoption/placement for adoption and is enrolling within 31 days of that event.
Marital Status*	Enter one of the following: Single, Married, Widowed, Legally Separated.

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