Leslie & Associates Benefit Alliance Enrollment Form for Kelly Services Employees

Mail to: 17304 Preston Rd. Suite 1070 Dallas, TX 75252

Member Name ______________________ (First / MI / Last) Social Security Number _____/_____/_____ Sex ______ Hire Date ______

Address ______________________ City ______________________ State ______ Zip ______

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

Email Address ______________________ Cell Phone ______ (Area Code) Latest Assignment Date ______

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 _____/_____/_____

GROUP TERM LIFE INSURANCE 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 per 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 1 (includes EPIC Hearing Plan)

	Plan 1 (Low)	***Plan 2 (High)***
Employee Only	☐ $ 28.32 monthly	☐ $ 43.50 monthly
Employee & Spouse	☐ $ 47.71 monthly	☐ $ 85.67 monthly
Employee & Children	☐ $ 59.48 monthly	☐ $ 88.27 monthly
Employee & Family	☐ $ 82.87 monthly	☐ $130.43 monthly

Monthly Premium ______

EYEMED VISION CARE PLAN

☐ Employee Only - $9.00 per month ☐ Employee & One *(Spouse or Child)* - $16.50 per month ☐ Employee & Family - $24.50 per month **Monthly Premium** ______

LegalGUARD LEGAL PLAN

☐ Employee, Spouse, Dependent Children & Employee and Spouse Elder Parents $ 17.97 per month **Monthly Fee** ______

LIFELOCK IDENTITY THEFT PROTECTION PLAN

	Benefit Elite Plan	***Advantage Plan***	***Ultimate Plus Plan***
Employee Only (18 & over)	☐ $ 8.49 per month	☐ $ 16.99 per month	☐ $ 25.49 per month
Employee & Spouse/Domestic Partner	☐ $ 16.98 per month	☐ $ 33.98 per month	☐ $ 50.98 per month
Employee & Children	☐ $ 14.86 per month	☐ $ 25.49 per month	☐ $ 36.11 per month
Employee & Family	☐ $ 23.36 per month	☐ $ 42.48 per month	☐ $ 61.61 per month

Monthly Fee ______

Note: By signing this form, you represent that you have the authority to enroll those dependents indicated on this form in LifeLock services and you further agree to LifeLock's Terms & Conditions which can be found at www.lifelock.com/terms on behalf of yourself and any other members of your family you are enrolling as indicated. Please contact the Benefit Alliance customer service department for the cancellation policy or a copy of LifeLocks Terms and Conditions.

See Reverse Side

GROUP LIMITED ACCIDENT & SICKNESS - ENHANCED PLANS (include separate Rx provision) Tier 3	Tier 4	GROUP LIMITED ACCIDENT & SICKNESS - STANDARD PLANS (no Rx provision) Tier 1	Tier 2
Employee Only ☐ $ 165.00 per month	☐ $ 280.00 per month	☐ $ 82.00 per month	☐ $ 103.00 per month
Employee & Spouse ☐ $ 343.00 per month	☐ $ 586.00 per month	☐ $ 169.00 per month	☐ $ 196.00 per month
Employee & Child(ren) ☐ $ 276.00 per month	☐ $ 471.00 per month	☐ $ 143.00 per month	☐ $ 165.00 per month
Employee & Family ☐ $ 460.00 per month	☐ $ 787.00 per month	☐ $ 232.00 per month	☐ $ 257.00 per month

Monthly Cost* ______________

I have read the Group Limited Accident & Sickness Plan enrollment materials and accept the terms and conditions outlined in them. 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 Doctor or required taking prescribed drugs or medicines within the 6 month period immediately preceding the effective date of coverage. The Limited Accident & Sickness Plan is group insurance underwritten by ACE American Insurance Company and the benefits will vary depending on the plan selected. The policy provides limited benefits on a fixed indemnity basis. I understand the policy is subject to exclusions, limitations. The limitations are disclosed in the enrollment materials, policy and certificate which are made available at the time of enrollment. I understand it does NOT constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). ☐ **Yes** ☐ **No**

* Monthly Cost includes $4.15 per Employee Network Access Fee

FIRST DOLLAR PLAN - SUPPLEMENTAL COVERAGE FOR EXISTING QUALIFIED MAJOR MEDICAL PLANS

Coverage Selection	***Employee Age Used to Determine Monthly Rates***	***Plan A $3,000/$1,500*** Inpatient/Outpatient	***Plan B $4,000/$2,000*** Inpatient/Outpatient	***Plan C $5,000/$2,500*** Inpatient/Outpatient	***Plan D $6,000/$3,00*** Inpatient/Outpatient
Employee Only	Employee Age______	☐ $ ________	☐ $ ________	☐ $ ________	☐ $ ________
Employee & Spouse	Employee Age______	☐ $ ________	☐ $ ________	☐ $ ________	☐ $ ________
Employee & Child(ren)	Employee Age______	☐ $ ________	☐ $ ________	☐ $ ________	☐ $ ________
Employee & Family	Employee Age______	☐ $ ________	☐ $ ________	☐ $ ________	☐ $ ________

Monthly Premium ______________

Note: By signing this form, I acknowledge a Qualified Major Medical Plan must be in force at the time claims are made for First Dollar Plan benefits. In addition, I understand initial applications and/or changes to first First Dollar Plan coverage must be made during designated open enrollment periods or within 30 days of my becoming eligible for a qualified individual or group major medical plan unless I meet the requirements for a qualifying life event. I hereby acknowledge I have a qualified major medical plan effective: ______________

SIMPLESAVE Rx PLAN

☐ Employee Only - $8.00 per month ☐ Employee & One *(Spouse or Child)* - $10.00 per month ☐ Employee & Family - $12.00 per month **Monthly Fee** ______________

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 ______________

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

TOTAL INITIAL PAYMENT MUST BE ENCLOSED ______________

(MAKE ALL PAYMENTS PAYABLE TO SPECIAL INSURANCE SERVICES, INC.)

Mail to: Leslie & Associates Benefit Alliance ◆ 17304 Preston Rd. Suite 1070 ◆ 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. This statement does not apply to the Limited Accident & Sickness Plans or Group Accident Plans underwritten by ACE American Insurance Company.

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.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information related to a claim was provided by the applicant.

Date ______________ Signature of Employee ______________________________ Daytime Phone (______)______________ Kelly Branch Number__________