AFL-AGC BUILDING TRADES
WELFARE & PENSION PLANS

P.O. Box 1492
Mobile, AL 36633
(251) 438-4765

Dear Participant:

According to our information, you have or may become eligible for benefits under this plan with your union employer. Please complete the enclosed application and designation of beneficiary form in order to expedite your enrollment. Please return it to this office with the enclosed envelope at your earliest convenience.

In addition to the completed and signed application, we will need the following items if applicable:

- Birth certificates for any dependent children to be covered
- Marriage license
- Completed Blue Cross Blue Shield Application(enclosed)
- Beneficiary Form(enclosed)

Failure to complete the BCBS application in a timely manner may result in difficulty utilizing your insurance coverage at such time as it may become effective.

IMPORTANT AFFORDABLE CARE ACT (ACA) NOTE: The individual shared responsibility provision requires you and each member of your family to have qualifying health coverage called minimum essential coverage. You are considered to have minimum essential coverage for months you are enrolled in and entitled to receive benefits under a plan or program that is minimum essential coverage. Please complete the enclosed application and return to properly enroll and receive verification of coverage for your tax filings. Additional information on the ACA minimum essential coverage and your responsibility please refer to www.irs.gov/Affordable-Care-Act

If you have any questions, please do not hesitate to call our office at 251-438-4765 or toll free at 1-800-828-2922.

Sincerely,

AFL-AGC Building Trades Welfare Plan

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Group ID:

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name: *First Name: MI:

*Social Security Number: *Birth Date (MM/DD/YYYY): *Gender: *Marital Status:

*Street Address: Email Address:

*City: *State: *ZIP Code: Telephone: ( )

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

Signature of Employee/Member_____ Date _____

Application

For Enrollment with Binding Arbitration

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001

BlueCross BlueShield of Alabama

ENR431-2110

BlueCross BlueShield of Alabama

Application For Enrollment

Fields marked with an * are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

* HEALTH GROUP NUMBER	* HEALTH DIVISION NUMBER	* DENTAL GROUP NUMBER	* DENTAL DIVISION NUMBER	* VISION GROUP NUMBER	* VISION DIVISION NUMBER

***NATURE OF APPLICATION** *(Check all that apply)*

NEW CONTRACT			CANCEL CONTRACT			CHANGE CONTRACT		
HEALTH	DENTAL	VISION	HEALTH	DENTAL	VISION	NAME CHANGE	ADDRESS CHANGE	TYPE COVERAGE CHANGE

ENROLLMENT PERIOD *(for new contracts)*

REGULAR ENROLLMENT ANNUAL OPEN ENROLLMENT SPECIAL OPEN ENROLLMENT

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*HOME MAILING ADDRESS		
*CITY	*STATE	*ZIP
*PHONE NUMBER HOME WORK CELL	E-MAIL ADDRESS (Optional)	
*GENDER MALE FEMALE	*DATE OF BIRTH (MM/DD/YYYY)	
*EMPLOYEE NUMBER		

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*RELATIONSHIP CHILD SPOUSE OTHER	*GENDER MALE FEMALE	*DATE OF BIRTH (MM/DD/YYYY)
ADD DEPENDENT	QUALIFYING EVENT TYPE: Marriage Birth/Adoption Loss of Coverage Other	* DATE EVENT OCCURRED
REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: Divorce Death Entered Military Service Request	* DATE EVENT OCCURRED

ADD HEALTH ADD DENTAL ADD VISION ADD ALL REMOVE HEALTH REMOVE DENTAL REMOVE VISION REMOVE ALL

DEPENDENT

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
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REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

DEPENDENT

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MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER	
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ADD HEALTH	ADD DENTAL	ADD VISION	ADD ALL
REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

If any dependent child above is over the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification after age 26, please list any dependent child applying for student extension.

NAME OF CHILD		NAME OF SCHOOL	
NAME OF CHILD		NAME OF SCHOOL	

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health, dental and/or vision plan or policy at the time this policy becomes effective? If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)	
NAME OF INSURANCE COMPANY	EMPLOYER'S NAME	
POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	GROUP NUMBER	TYPE COVERAGE SINGLE FAMILY

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete the information below.

If you have Individual coverage, please call Customer Service at **1-855-350-7441** to cancel your contract. If your Individual coverage is through the Federal Marketplace, please call the Marketplace at **1-800-318-2596** to cancel your contract.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	MEDICARE NUMBER

PART A	EFFECTIVE DATE (MM/DD/YYYY)	PART B	EFFECTIVE DATE (MM/DD/YYYY)
PART C	EFFECTIVE DATE (MM/DD/YYYY)	PART D	EFFECTIVE DATE (MM/DD/YYYY)

TO BE COMPLETED BY EMPLOYEE

I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.

I am requesting cancellation of my existing benefits as checked above.

I apply for the Group Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group agent or Remitting Agent. I ask my Group to pay you directly and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health, dental and/or vision policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

THE GROUP PLAN UNDER WHICH YOU ARE APPLYING FOR COVERAGE INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT OTHER THAN A CLAIM FOR BENEFITS UNDER SECTION 502(a) OF ERISA WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE GROUP PLAN.

*SIGNATURE OF EMPLOYEE

DATE SIGNED (MM/DD/YYYY)		FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)	

TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME	*GROUP NUMBER

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION
*GROUP ADMINISTRATOR'S SIGNATURE	DATE SIGNED (MM/DD/YYYY)

IMPORTANT DISCLOSURE NOTICE

NOTICE OF GROUP HEALTH, DENTAL AND VISION PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health, dental and/or vision plan benefits for yourself or your dependents (including your spouse) because of other health, dental and/or vision insurance or group health, dental and/or vision plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement as an eligible foster child, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, placement for adoption, or placement as an eligible foster child.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

NOTICE OF GROUP DENTAL PLAN BENEFIT WAITING PERIODS

This dental plan includes benefit waiting periods that you may have to serve before certain benefits begin to be covered under this dental plan. Please refer to the section in your benefit booklet called "Benefit Waiting Periods."

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE FOR GROUP HEALTH PLANS

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.