



EUGENE BURGER  
MANAGEMENT  
CORPORATION

## UNIVERSAL ENROLLMENT FORM

### I. PERSONAL INFORMATION

1. Name (Last, First, M.I.)		2. Social Security Number - -	
3. Address (Number, Street, City, State, ZIP Code)		4. Phone No. ( )	
5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Date of Birth (MM/DD/YY) / /	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	9. Date of Hire (MM/DD/YY) / /
10. Job Title			

### II. TRANSACTION INFORMATION

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Other Mid-Year Change _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Add Dependent
Effective Date of Change:
If other mid-year change, please indicate reason:

### III. PLAN CHOICES

Health Benefit Plans	Requested Change	Coverage Level	Monthly Premium
MEDICAL United Healthcare PPO Group # 575595	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 317.14 \$ 937.72 \$ 834.28 \$1,351.46
MEDICAL Pacificare HMO (CA Only) Group # 526455	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 271.22 \$ 836.68 \$ 742.44 \$1,213.67
MEDICAL Kaiser Permanente HMO (CA Only) N. CA – Group # 600643-1 S. CA – Group # 229243-2	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 276.66 \$ 848.64 \$ 753.31 \$1,229.97
MEDICAL Kaiser Permanente HSA (CA Only) N. CA – Group # 600643-2 S. CA – Group # 229243-3	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 158.11 \$ 587.84 \$ 516.22 \$ 874.32

DENTAL Ameritas Dental High Option Group # 29349-00001	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 49.84 \$ 94.04 \$ 107.92 \$ 152.08
DENTAL Ameritas Dental Low Option Group # 29349-00001	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family	\$ 25.16 \$ 47.20 \$ 57.68 \$ 79.72
VISION Ameritas Group # 29349-00002	<input type="checkbox"/> Elect	<input type="checkbox"/> Employee Only <input type="checkbox"/> EE + One Dependent <input type="checkbox"/> EE + Two or More Dependents	\$ 10.32 \$ 18.04 \$ 24.76

Sun Life Benefit Plans	Requested Change	Coverage Level	Monthly Premium
Optional Buy Up Life	<input type="checkbox"/> Elect	<input type="checkbox"/> See Enrollment Form	See Enrollment Form
Voluntary Accidental Death & Dismemberment (AD&D)	<input type="checkbox"/> Elect	<input type="checkbox"/> See Enrollment Form	See Enrollment Form
Long Term Disability	<input type="checkbox"/> Elect	<input type="checkbox"/> See Enrollment Form	See Enrollment Form
Short Term Disability (NV Only)	<input type="checkbox"/> Elect	<input type="checkbox"/> See Enrollment Form	See Enrollment Form

**Important Notice:** If coverage is elected, a Sun Life Enrollment Form must be filled-out. There is a six month wait period (from date of hire) before coverage becomes effective. Should you decline coverage now and want it at a later date, you will have to provide evidence of insurability (proof of good health).

#### IV. COVERAGE WAIVER / DECLINATION

I am declining coverage for myself and/or dependents for the following reason (check all boxes that apply):

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Medical               | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Medicare           | <input type="checkbox"/> Other Reason _____ |
| <input type="checkbox"/> Dental                | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Medicare           | <input type="checkbox"/> Other Reason _____ |
| <input type="checkbox"/> Vision                | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Medicare           | <input type="checkbox"/> Other Reason _____ |
| <input type="checkbox"/> Optional Buy Up Life  | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Other Reason _____ |   |
| <input type="checkbox"/> Voluntary AD&D        | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Other Reason _____ |   |
| <input type="checkbox"/> Long Term Disability  | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Other Reason _____ |   |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Covered by Spouse's Plan | <input type="checkbox"/> Covered by Individual Plan | <input type="checkbox"/> Other Reason _____ |   |

If you have a qualifying event, please notify Human Resources **within 30 days of this change**. Qualifying events include:

- Marriage or divorce
- Spouse terminates employment or becomes employed
- Birth or adoption of a child
- Unpaid leave of absence taken by you or your spouse
- Death of a spouse or child
- Full-time to part-time change (or vice versa)

**V. EMPLOYEE AND FAMILY INFORMATION** Please complete for yourself and each covered dependent

Last Name	First Name	Date of Birth	Sex	Social Security Number	If PacifiCare HMO, Primary Care Physician Name and ID#
Self		____/____/____		____-____-____	
Spouse/Domestic Partner		____/____/____		____-____-____	
Child		____/____/____		____-____-____	
Child		____/____/____		____-____-____	
Child		____/____/____		____-____-____	

- Do any of the above have other health insurance?  Yes  No  
If yes, please list names \_\_\_\_\_
- Are any of the above dependents (spouse and/or children) totally disabled?  Yes  No  
If yes, please list names \_\_\_\_\_
- Are all the above children full-time students (if between ages of 19 and 24)  Yes  No  
If no, please list names \_\_\_\_\_

**VI. PRIOR COVERAGE FOR UNITED HEALTHCARE PPO PLAN ONLY**

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. United Healthcare reserves the right to request a copy of this certificate.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason For Ending Coverage
Self				
Spouse / Partner				
Child				
Child				
Child				

**VII. MEDICARE INFORMATION, IF APPLICABLE:**

Are you retired?  YES  NO Medicare for you: Part A  YES  NO Part B  YES  NO Do your dependents have Medicare? Part A  YES  NO Part B  YES  NO

Names of Medicare dependents: \_\_\_\_\_

If yes for Medicare, for you and/or your dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB# \_\_\_\_\_ Entitlement Reason:  Over 65  Disabled  ESRD  
HIB# \_\_\_\_\_ Entitlement Reason:  Over 65  Disabled  ESRD

Effective Date of Medicare: \_\_\_\_\_ Name: \_\_\_\_\_  
Effective Date of Medicare: \_\_\_\_\_ Name: \_\_\_\_\_

### VIII. HEALTH SPENDING ACCOUNT (HSA) – FOR UNITED PPO & KAISER DHMO ENROLLEES ONLY

As an employee enrolled in the United Healthcare High Deductible PPO plan, you are eligible to contribute pre-tax dollars in to a Health Spending Account through Sterling HSA. Please complete the Sterling H.S.A enrollment form to enroll.

### IX. EMPLOYEE ACKNOWLEDGEMENT

I request benefits under the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply or, as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct. I understand and agree that any incorrect statements material to the plan made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

To the best of my knowledge, I am an employee working the weekly hours shown on page 1 at the employer's regular place of business, and I agree any information shown, including the refusal section, is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

#### PLEASE READ CAREFULLY

**I. DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required dues.

**II. NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**III. HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

**IV. EFFECTIVE DATE:** The effective date of coverage is subject to carrier approval.

**V. Arbitration Agreements & Release Statements (please sign coverages applied for only):**

**PacifiCare Arbitration Agreement:** I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

X \_\_\_\_\_  
Employee Signature      Date

**United Healthcare Agreement:** I confirm that the information I have provided on this form is complete and accurate. I understand that the health plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with out information so that it is no longer individually identifiable and use it for commercial and other purposes.

X \_\_\_\_\_  
Employee Signature      Date

**Kaiser Foundation Health Plan Arbitration Agreement:**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

X \_\_\_\_\_  
Employee Signature      Date  
Required for Kaiser Permanente HMO and DHMO Plans (CA Only)

**Dental & Vision Plans**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. **THE FOLLOWING APPLIES ONLY TO SECTION 125 BENEFIT PLANS:** I am signing up for coverage until the next open enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X \_\_\_\_\_  
Employee Signature      Date

**PLEASE READ AND SIGN (pertinent to all EBMC employee benefit plans):**

I have read and understand the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in the future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files.

X \_\_\_\_\_  
Employee Signature      Date

# Sun Life Assurance Company of Canada

## Beneficiary Designation



You may use this form to designate who will receive the Group Life Insurance proceeds in the event of your death.

The designations you make on this form replace any prior beneficiary designations.

Designations apply to your Basic as well as any Optional Life Insurance you have under your Group Policy. If you would like different beneficiaries for your Basic and Optional coverages, please indicate that below.

See Page 2 of this form for sample beneficiary designations and more information.

### 1 Employee and employer information

Please print clearly

Your Name (first, middle initial, last)		Social Security Number	
Employer's Name	Group Policy Number	Billing Group Number	

### 2 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the Group Life Insurance proceeds in the event of your death.

Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Group Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

Primary Beneficiary(ies)		Social Security Number	Relationship to Employee	Percent Share of Proceeds*
1.	Name: Address:			%
2.	Name: Address:			%

Secondary (Contingent) Beneficiary(ies)		Social Security Number	Relationship to Employee	Percent Share of Proceeds*
1.	Name: Address:			%
2.	Name: Address:			%

\* The total within each class (Primary and Secondary) must equal 100%.

### 3 Signature

**Employers:** Keep the signed original copy of this form with the employee's records.

**Important:** You must sign and date this form for your designation to become effective. Make a copy for your records and return the signed original to your employer.

Signature of Employee X	Date Signed
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Continued on next page



**Beneficiary Wording Alternatives**

Proposed Beneficiary(ies)	Suggested Wording
1. Estate	Estate
2. One beneficiary	Martha Doe, wife
3. More than one beneficiary in equal shares	Jane Doe, Mary Doe and Richard Doe, children, or survivor(s) of them, in equal shares.
4. Two beneficiaries, in succession	Primary: Martha Doe, wife; Secondary: Richard Doe, son. <i>(Richard will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
5. One beneficiary followed by two beneficiaries in equal shares	Primary: Martha Doe, wife; Secondary: Jane Doe and Mary Doe, children in equal shares, or the survivor of them. <i>(Jane and Mary will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
6. More than one Beneficiary in equal shares per descendent order	Jane Doe, Mary Doe and Richard Doe, or the survivor(s) of them, in equal shares. However, if any of my children predecease me and leave issue who survive me, the issue of the deceased child will receive their parents' share in equal shares.
7. One or more minor children	John Smith, as custodian for Jane Doe, a minor, under the Uniform Transfers to Minors Act (UTMA) so that proceeds can be paid before the child reaches the age of majority.
8. To a church or non-profit organization	Name and address of the beneficiary organization.
9. Beneficiaries shown in percentages	John Smith, brother - 40%, or in the event of his death, to my estate; Alan Smith, brother 60%, or in the event of his death, to my estate.
10. Trust under Last Will and Testament	Proceeds to be paid to the Trustee under my Last Will and Testament.
11. Existing Trust	Jane Doe, Trustee of the Doe Family Trust, dated 1/1/2001.

**Please Note:** You cannot name your employer as a beneficiary for Group Life Insurance proceeds under the Group Policy.

Dependent Life Insurance benefits are payable to the employee, or the employee's estate if the employee does not survive the dependent.

**Sun Life Assurance Company of Canada is not a tax or legal advisor and the above information is provided as general information only. Before making beneficiary designations, you may want to consult with your tax or legal advisor.**

# Sun Life Assurance Company of Canada

## Optional Life Enrollment Form



### 1 Employer and Employee Information (Please print clearly)

Name of your employer <b>EBMC</b>	Policy number <b>20691</b>	Benefit group or class <b>All Full-Time Employees</b>	Your basic annual earnings* \$		
Your full legal name (first, middle initial, last)		Social Security Number	Date of birth	Date of hire	Your occupation

### 2 Benefit Elections (Make your benefit elections below based on the coverage options described here)

**Employee coverage:** You can purchase 1, 2, 3 or 4 times your basic annual earnings\* up to \$250,000. Amounts available with no evidence of insurability required: \$150,000 if you are under age 60; \$40,000 if age 60-69; \$20,000 if age 70-79; and \$1,000 if age 80 or over. **Age Reductions:** To 65% at age 65 and 50% at age 70. Benefits cease at retirement.

	<b>Coverage amount selected</b>	<b>I decline coverage</b>
<b>Employee coverage:</b>	<input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x <input type="checkbox"/> 4 x	<input type="checkbox"/>

\* Basic annual earnings do not include bonuses, commissions or overtime pay.

#### About Evidence of Insurability (also known as Proof of Good Health):

Evidence of Insurability (EOI) is needed if:

- You apply for higher coverage than the than the limits described in the Coverage Options above.
- You want to increase your existing coverage now (whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier).
- You want to increase your coverage at a later date.
- You decline coverage and then want it at a later date.

If EOI is needed, your coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

### 3 Acknowledgment and Signature (Important: You must read and sign for coverage)

I understand that:

- I am requesting Optional Life coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage now and want it at a later date, I will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the "About Evidence of Insurability" notice on page 2.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Optional Life coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.

Signature of employee X	Date signed
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#### 4 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event of your death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

Use my Basic Life beneficiaries – Check this box and leave this section blank if you want your Optional Life Insurance beneficiaries to be the same as your Basic Life beneficiaries.

If you did not check the box above, make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Primary beneficiary(ies)		Social Security Number	Relationship to employee	Percent share of proceeds *
1.				
2.				
Secondary (Contingent) beneficiary(ies)		Social Security Number	Relationship to employee	Percent share of proceeds *
1.				
2.				

\* The total within each class (Primary and Secondary) must equal 100%.

#### 5 Calculating Your Cost

##### Employee coverage:

- Find your age in the chart below and the corresponding cost.
  - Multiply the cost per \$1,000 by your amount of coverage (divided by 1,000).
- Your cost will increase when you move into a new age band.

Age	EMPLOYEE Monthly cost per \$1,000 of coverage
Under 29	\$ 0.08
30-34	\$ 0.09
35-39	\$ 0.13
40-44	\$ 0.17
45-49	\$ 0.27
50-54	\$ 0.44
55-59	\$ 0.81
60-64	\$ 1.04
65-69	\$ 1.86
70+	\$ 2.04

**Employee:** Make a copy of this form for your records before submitting it to your employer.

**Employers:** This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another Optional Life Enrollment Form.

# Sun Life Assurance Company of Canada

## Voluntary Accidental Death and Dismemberment (AD&D) Enrollment Form



### 1. Employer, Employee and Dependent Information (Please print clearly)

Name of your employer <b>EBMC</b>	Policy number <b>20691</b>	Benefit group or class <b>All Full Time employees</b>	Your basic annual earnings* \$	
Your full legal name (first, middle initial, last)		Social Security Number	Date of birth	Date of hire
Your spouse's name (first, middle initial, last)**		Social Security Number	Date of birth	Date of marriage
Name(s) of child(ren) to be covered (attach additional pages if needed)**			Date(s) of birth	

### 2 Benefit Elections (Make your benefit elections below based on the coverage options described here)

**For yourself:** You can purchase 1, 2, 3, 4 or 5 times your basic annual earnings up to \$500,000.00\*

**For your spouse:** Coverage equals 40% of employee amount. Spouse coverage will be raised to 50% of employee amount if there are no covered children at time of death.

**For your eligible children:** Coverage equals 10% of employee amount. Child coverage will be raised to 15% of employee amount if there is no covered spouse at time of death. For a description of children eligible for coverage, refer to the group insurance booklet or ask your employer.

	I elect coverage	I decline coverage	Coverage amount selected
Employee coverage:	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	40% of employee amount
Child(ren) coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	10% of employee amount

\* Basic annual earnings do not include bonuses, commissions or overtime pay.

\*\* Your spouse and children may only be covered if you are.

### 3 Acknowledgment and Signature (Important: You must read and sign for coverage)

I understand that:

- I am requesting Voluntary Accidental Death and Dismemberment (AD&D) insurance coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage for me or my family now, I/we will not be able to re-enroll for at least six months.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Voluntary AD&D coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- If my spouse or any of my dependent children are hospital-confined or are disabled due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer hospital-confined or disabled and are able to perform their normal activities.

Signature of employee X	Date signed
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Continued on Page 2

#### 4 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the AD&D proceeds in the event of your accidental death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the AD&D proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your accidental death.

If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

Make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Proceeds for other losses, such as accidental dismemberment or accidental death of a covered family member, will be paid to you.

Primary beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

Secondary (Contingent) beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

\* The total within each class (Primary and Secondary) must equal 100%.

#### 5 Calculating Your Cost (Find your monthly cost by adding all of the coverages you have selected)

Your monthly cost for Voluntary AD&D Insurance is based on the coverage option you select.

- Find the coverage option you have selected in the chart below and the associated cost.
- Multiply the cost per \$1,000 by your total amount of coverage.

<b>Cost for option selected (see below)</b>	<b>Total amount of coverage divided by 1,000</b>	<b>X</b>	<b>Your monthly cost</b>	<b>=</b>	<b>\$</b>
\$	\$				

Your Coverage	Monthly cost per \$1,000 of coverage
Employee coverage	\$ 0.030
Employee and Family coverage	\$ 0.050

**Employee:** Make a copy of this form for your records before submitting it to your employer.

**Employers:** This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another Voluntary AD&D Enrollment Form.

# ENROLLMENT FOR LONG TERM DISABILITY BENEFITS

FOR EMPLOYEES OF **Eugene Berger Management Corporation #20691**

Welcome to Sun Life Assurance Company of Canada. We are pleased to provide you with Long Term Disability benefits. Below is an outline of the benefits now available to you through your employer.

## Your LTD Benefits

Available to all full time employees working 32 or more hours per week.

- Covers accidents and sicknesses.
- Benefits are 60% of monthly earnings up to a maximum of \$6,000 per month.
- Benefits may begin after 365 days of absences due to a covered accident or sickness.
- Coverage is entirely employee paid.

## Cost to You

Long Term Disability coverage is contributory, meaning that you are responsible for paying for all of the cost through payroll deduction. Your cost is determined by multiplying your monthly earnings by the rate found in the rate chart below.

Your Age	Rate
Under 55	\$ .423
56 - 60	\$ 1.166
61 +	\$ 1.132

Example Monthly Earnings	Divided by 100	Multiplied by rate	Total cost
\$ 3,500	/ 100 = 35	x \$0.423	= \$14.81

Example cost per month
\$ 14.81

Your Monthly Earnings	Divided by 100	Multiplied by rate	Total cost
\$	/ 100 =	x \$	= \$

Your cost per month
\$

## How to Enroll

Fill out the Long Term Disability enrollment form below. Be sure to sign, date, and return the form to your employer.

Name (First, middle initial, last)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No.	Date of Birth	Date of Hire
<b>You must elect or refuse insurance coverage within 31 days of your date of eligibility.</b> Long Term Disability (LTD) coverage. Check One: <input type="checkbox"/> I elect <input type="checkbox"/> I decline				Monthly Earnings \$
<b>Important. You must read and sign. I understand that:</b> <ul style="list-style-type: none"> <li>• I am requesting LTD coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.</li> <li>• My employer will deduct all or part of the premiums from my pay.</li> <li>• If I decline coverage now and want it at a later date, I will have to provide evidence of insurability (proof of good health) acceptable to Sun Life Assurance Company of Canada.</li> <li>• Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.</li> </ul>				
Employee Signature				Today's Date

This summary flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under the plan. When you become eligible for benefits under the plan, your employer will provide you with the Sun Life Assurance Company of Canada Group LTD booklet containing complete plan details.

# HIGHLIGHTS OF LONG TERM DISABILITY BENEFITS

FOR EMPLOYEES OF Eugene Berger Management Corporation #20691

Welcome to Sun Life Assurance Company of Canada. We are pleased to provide you with Long Term Disability benefits. Below is an outline of the benefits now available to you through your employer.

## Your LTD Benefits

Available to all full time employees working 32 or more hours per week.

- Covers accidents and sicknesses.
- Benefits are 60% of monthly earnings up to a maximum of \$6,000 per month.
- Benefits may begin after 365 days of absences due to a covered accident or sickness.
- Coverage is entirely employee paid.

## Cost to You

Long Term Disability coverage is contributory, meaning that you are responsible for paying for all of the cost through payroll deduction. Your cost is determined by multiplying your monthly earnings by the rate found in the rate chart below.

Your Age	Rate
Under 55	\$ .423
56 - 60	\$ 1.166
61 +	\$ 1.132

Example Monthly Earnings	Divided by 100	Multiplied by rate	Total cost
\$ 3,500	/ 100 = 35	x \$0.423	= \$14.81

Example cost per month
\$ 14.81

Your Monthly Earnings	Divided by 100	Multiplied by rate	Total cost
\$	/ 100 =	x \$	= \$

Your cost per month
\$

## How to Enroll

Fill out the Long Term Disability enrollment form available from your employer. Be sure to sign, date, and return the form to your employer.

This summary flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under the plan. When you become eligible for benefits under the plan, your employer will provide you with the Sun Life Assurance Company of Canada Group LTD booklet containing complete plan details.



**EUGENE BURGER  
MANAGEMENT  
CORPORATION**

**Employee  
Benefits Program for  
California Employees**

Effective

May 1, 2010 – April 30, 2011

IMPORTANT PHONE NUMBERS	
PACIFICARE – HMO MEMBER SERVICES WEBSITE	(800) 624-8822 www.pacificare.com
KAISER - HMO MEMBER SERVICES WEBSITE	(800) 464-1000 www.kp.org
UNITED HEALTHCARE - PPO MEMBER SERVICES WEBSITE	(800) 357-0978 www.myuhc.com
AMENTAS – DENTAL AND VISION MEMBER SERVICES WEBSITE	(800) 487-5555 www.amentasgroup.com
SUNLIFE – LIFE/AD&D AND DISABILITY MEMBER SERVICES WEBSITE	(800) 247-6875 www.sunlife-usa.com
STERLING – HEALTH SAVINGS ACCOUNT MEMBER SERVICES WEBSITE	(800) 617-4729 www.sterlingsa.com
MYCLEARBENEFITS	www.myclarbenefits.com User ID: ebmc2 Password: benefits2
EZLN HELP LINE HELP LINE	(707) 540-9930

Courtesy of Woodruff-Sawyer & Co.



T 415.878.2460  
F 415.878.4916

88 Rowland Way, Suite 180  
Novato, CA 94945

LIFE/AD&D BENEFITS – SUNLIFE	
ALL EXECUTIVES, PROPERTY MANAGERS AND SUPERVISORS	FLAT \$20,000
ALL RESIDENTIAL MANAGERS, SITE PERSONNEL AND CORPORATE OFFICE STAFF	FLAT \$10,000

VOLUNTARY LIFE – SUNLIFE	
EMPLOYEE	1X, 2X, 3X OR 4X ANNUAL SALARY TO \$250,000. EVIDENCE OF INSURABILITY REQUIRED FOR AMOUNTS OVER \$150,000 (AGE 60-69 \$40,000 / AGE 70-79 \$20,000 / AGE 80 & OLDER \$1,000).

VOLUNTARY AD&D – SUNLIFE	
EMPLOYEE	1X, 2X, 3X, 4X OR 5X ANNUAL SALARY TO \$500,000.
SPOUSE	40% OF EMPLOYEES ELECTED AMOUNT (50% IF NO CHILDREN)
CHILD(REN)	10% OF EMPLOYEES ELECTED AMOUNT (15% IF NO SPOUSE)

VOLUNTARY LONG TERM DISABILITY – SUNLIFE (All Employees)	
BENEFIT	60% to \$6,000 per Month
ELIMINATION PERIOD	365 days
MAXIMUM BENEFIT PERIOD	60 months

HEALTH SAVINGS ACCOUNT (HSA) ADMINISTERED BY STERLING		
Employees participating in either the Kaiser HMO H.S.A. eligible plan or the United Healthcare PPO H.S.A. eligible plan are eligible to set aside pre-tax dollars (Federal level only) in to a Health Savings Account with Sterling. Please see medical summaries above for annual funding amounts. These funds can be used to pay for your eligible medical, dental and/or vision expenses. Below are the calendar year contribution limits for 2009 and 2010.		
Plan Year	Individual Coverage	Family Coverage
2009	\$3,050	\$5,950
2010	\$3,050	\$6,150

# Eugene Burger Management Corporation

Benefits Effective May 1, 2010

MEDICAL - HMO PLAN OPTIONS			
	PacificCare HMO	Kaiser HMO	Kaiser H.S.A.
CALENDAR YEAR DEDUCTIBLE	None	\$1,000 / Individual \$2,000 / Family	\$2,000 / Individual \$4,000 / Family
MAXIMUM CALENDAR YEAR OUT OF POCKET	\$5,000 / Individual \$15,000 / Family	\$3,000 / Individual \$6,000 / Family	\$3,000 / Individual \$6,000 / Family
LIFETIME PLAN MAXIMUM	Unlimited	Unlimited	Unlimited
HOSPITALIZATION			
PER ADMISSION HOSPITAL COPY	None	None	\$250 Copy
SEMI-PRIVATE ROOM & BOARD	50%	20% after Deductible	Covered 100% after Deductible
EMERGENCY ROOM	\$100 Copy Waived if admitted	20% after Deductible	\$100 Copy after Deductible
PHYSICIAN SERVICES			
OFFICE VISIT	\$20 PCP \$40 Specialist	\$30 Copy Deductible waived	\$30 Copy after Deductible
WELL BABY CARE	Covered 100% to age 2	\$10 Copy through 23 months Deductible waived	\$10 Copy through 23 months Deductible waived
ROUTINE EXAMS	\$20 Copy	\$30 Copy Deductible waived	\$30 Copy after Deductible
MATERNITY (PRE- / POST-NATAL CARE)	\$20 Copy	\$10 Copy Deductible waived	\$10 Copy Deductible waived
PRESCRIPTION DRUGS			
PRESCRIPTIONS	\$15 Generic \$30 Brand \$45 Non-Formulary	\$10 Generic \$30 Brand after \$250 Brand Deductible	\$10 Generic \$30 Brand

MEDICAL - PPO PLAN OPTION		
	United Health Care H.S.A Eligible PPO	Non-Network
CALENDAR YEAR DEDUCTIBLE	\$1,500 / Individual \$3,000 / Family	\$3,000 / Individual \$6,000 / Family
MAXIMUM CALENDAR YEAR OUT OF POCKET	\$3,000 / Individual \$4,000 / Family	\$6,000 / Individual \$12,000 / Family
LIFETIME PLAN MAXIMUM	Unlimited	\$1,000,000
HOSPITALIZATION		
PER ADMISSION HOSPITAL COPY	None	None
SEMI-PRIVATE ROOM & BOARD	20% after Deductible	40% after Deductible
EMERGENCY ROOM	20% after Deductible	20% after Deductible
PHYSICIAN SERVICES		
OFFICE VISIT	20% after Deductible	40% after Deductible
WELL BABY CARE	Covered 100%	Not Covered
ROUTINE EXAMS	Covered 100%	Not Covered
MATERNITY (PRE- / POST-NATAL CARE)	Covered 100%	Not Covered
PRESCRIPTION DRUGS		
PRESCRIPTIONS	Covered after Deductible \$10 Tier 1 \$30 Tier 2 \$50 Tier 3	

VISION - AMERITAS (ASP NETWORKS)		
	Network	Non-Network
PLAN COBAT	\$20 Exam / \$20 Materials	
EXAMINATION & LENSES	Every 12 months	
FRAMES	Every 24 months	
SCHEDULE OF ALLOWANCES	Network	Non-Network
VISION EXAM	100%	Up to \$17 Paid
LENSES SINGLE VISION BIFOCALS TRIFOCALS	100% 100% 100%	Up to \$48 Paid Up to \$69 Paid Up to \$85 Paid
CONTACTS MEDICAL NECESSARY ELECTIVE	100% Up to \$120	Up to \$210 Up to \$105
FRAMES	Up to \$120 Retail	Up to \$45 Retail

DENTAL - AMERITAS (CON OPTION)		
	NETWORK	NON-NETWORK
ANNUAL DEDUCTIBLE	\$50 per person / \$150 per family	
ANNUAL BENEFIT MAXIMUM	\$1,500	
PREVENTIVE SERVICES (CLEANINGS, EXAMS, X-RAYS)		
BASIC SERVICES (EXTRACTIONS, FILLINGS, PERIODONTICS)		Refer to Summary Plan Description for Allowance Schedule
MAJOR SERVICES (CROWNS, INLAYS, DENTURES)		
ORTHODONTIA		Not Covered

DENTAL - AMERITAS (EIG OPTION)		
	NETWORK	NON-NETWORK
ANNUAL DEDUCTIBLE	\$50 per person / \$150 per family	
ANNUAL BENEFIT MAXIMUM	\$1,500	
PREVENTIVE SERVICES (CLEANINGS, EXAMS, X-RAYS)	Covered 100% Deductible Waived	Covered 100% of UCR Deductible Waived
BASIC SERVICES (EXTRACTIONS, FILLINGS, PERIODONTICS)	Covered 80%	Covered 80% of UCR
MAJOR SERVICES (CROWNS, INLAYS, DENTURES)	Covered 50%	Covered 50% of UCR
ORTHODONTIA		Not Covered