

**EBS Employee Benefit Services, Inc.**  
**Renewal Form, Issue Date: 09/12/2006**

Acme, John R  
 123 Acme Ln  
 San Antonio, TX 78228  
 210-555-5555

AAA Acme  
 4318 Woodcock Dr., Ste. 130  
 San Antonio, TX 78228  
 210-738-1414

Employment Date:	01/01/2001	Effective Date:	01/01/2004
SSN:	123-45-6789	Gender:	M
Occupation:	President/CEO	DOB:	06/06/1966
Marital Status:	M	Salary:	\$66666
Level:	1	Pay Period:	24
Location:		Medical Effective:	/ /

Election	Description	PPD
Medical - EBS - Grp #: AAA0102		
A	Employee Only	\$0.00
B	Employee & Child(ren)	\$63.88
C	Employee & Spouse	\$88.88
=> D	Employee & Family	\$113.88

Currently Selected Election: D                      Option Elected: \_\_\_\_\_

Dental - EBS - Grp #: AAA0102		
A	Employee Only	\$0.00
=> B	Employee & Family	\$15.00

Currently Selected Election: B                      Option Elected: \_\_\_\_\_

Employee Term Life - ABC Insurance Co.			
A	\$50000	Base Life/AD&D Insurance	\$0.00
B	\$50000 + \$67000	Additional Life/AD&D Insurance	\$5.36
=> C	\$50000 + \$100000	Additional Life/AD&D Insurance	\$8.00
D	\$50000 + \$200000	Additional Life/AD&D Insurance	\$16.00
E	\$50000 + \$267000	Additional Life/AD&D Insurance	\$21.36

Currently Selected Election: C                      Option Elected: \_\_\_\_\_

Spouse Life - ABC Insurance Co.			
A		Waive Spouse Life Coverage	\$0.00
=> B	\$25000	Spouse Life Coverage	\$3.13

Currently Selected Election: B                      Option Elected: \_\_\_\_\_

Child Life - ABC Insurance Co.			
=> A		Waive Child(ren) Life Coverage	\$0.00
B	\$5000	Child(ren) Life Insurance	\$0.38

Currently Selected Election: A                      Option Elected: \_\_\_\_\_

**EBS Employee Benefit Services, Inc.**  
**Renewal Form, Issue Date: 09/12/2006**

Acme, John R  
 123 Acme Ln  
 San Antonio, TX 78228  
 210-555-5555

AAA Acme  
 4318 Woodcock Dr., Ste. 130  
 San Antonio, TX 78228  
 210-738-1414

Employment Date:	01/01/2001	Effective Date:	01/01/2004
SSN:	123-45-6789	Gender:	M
Occupation:	President/CEO	DOB:	06/06/1966
Marital Status:	M	Salary:	\$66666
Level:	1	Pay Period:	24
Location:		Medical Effective:	/ /

Voluntary STD - ABC Insurance Co.

A		Waive STD Coverage	\$0.00
=> B	\$500	Weekly Benefit	\$12.50

Currently Selected Election: B                      Option Elected: \_\_\_\_\_

Voluntary LTD - ABC Insurance Co.

A		Waive LTD Coverage	\$0.00
=> B	\$3334	LTD Monthly Benefit	\$13.89

Currently Selected Election: B                      Option Elected: \_\_\_\_\_

Dependents:  Check here if you wish to keep your dependent coverage exactly as listed on the last page of this form.  
 Check here if you wish to change your dependent coverage. (Use the following spaces to do so).

Name	Birthdate	Gender	Social Security Number	Graduation Date	Med Dtl	Lif
Spouse _____	___/___/___	M F	____-____-____	___/___/___	___	___
Child1 _____	___/___/___	M F	____-____-____	___/___/___	___	___
Child2 _____	___/___/___	M F	____-____-____	___/___/___	___	___
Child3 _____	___/___/___	M F	____-____-____	___/___/___	___	___
Child4 _____	___/___/___	M F	____-____-____	___/___/___	___	___
Child5 _____	___/___/___	M F	____-____-____	___/___/___	___	___

Do any of the above named dependents have a HIPAA certificate showing prior creditable coverage? Yes  No   
 Are any of the above named dependents covered by another group health plan? Yes  No

Beneficiaries:  Check here if you wish to keep your beneficiary designations exactly as listed on the last page of this form.  
 Check here if you wish to change your beneficiary designations. (Use the following spaces to do so).

	First Name	Last Name	Relationship	Pct.
Primary Beneficiary	_____	_____	_____	_____%
Primary Beneficiary	_____	_____	_____	_____%

If your primary beneficiary(ies) are not living when you die, list the individual(s) you wish to receive the proceeds.

Contingent Beneficiary	_____	_____	_____	_____%
Contingent Beneficiary	_____	_____	_____	_____%

\*\*\*\*\*

I hereby authorize a reduction in my monthly salary in accordance with my election(s) under the Flexible Benefit Cafeteria Plan as adopted by AAA Acme, Inc.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**EBS Employee Benefit Services, Inc.**  
**Personal Confirmation Form, Dependents and Beneficiaries**

Employee: Acme, John R

123-45-6789

---

Name	SSN	Relationship	Sex	DOB	Status
Judy Acme <b>Md Eff:</b> 01/01/2002	987-65-4321 Benefits: Dental Medical Spouse Life	Spouse	F	07/07/1967	
James Acme <b>Md Eff:</b> 01/01/2002	555-55-5555 Benefits: Dental Medical	Child	M	07/05/1997	
Beneficiary: Judy Acme		Spouse			100% primary
Beneficiary: James Acme		Son			100% contingent

---