24/7 CUSTOMER PHILIPPINES, INC.
HEALTH INSURANCE PLAN FOR EXTENDED FAMILY
via MEDICARD
(Contract Year: January 1, 2013 – December 31, 2013)

ENROLLMENT FORM FOR DEPENDENTS
(For Single Employees Only)

INFORMATION ON EMPLOYEE:

Employee Number	Last Name	First Name	Middle Initial	Extension Name (Jr., III)
Birth Date (mm/dd/yyyy)	**Sex** ☐ Male ☐ Female	**Civil Status** ☐ Single ☐ Single Parent	**Job Grade** ☐ I ☐ J ☐ A ☐ C ☐ B ☐ D	Presently enrolled under Medicard as a DEPENDENT of a current 24/7 employee? ☐ YES ☐ NO

[ ] **NO,** I am not enrolling my dependents (i.e., parents) in the Plan. I understand that should I wish to enroll them later, I may do so only during the enrollment period prior to the start of the next contract year.

[ ] **YES**, I wish to enroll my eligible dependents under the Plan. This serves as a continuing authorization for the Company to effect the semi-monthly deductions from my salary, as follows:

Membership Fees				
HIP for Extended Family Coverage				
Plan Options	**Room and Board / MBL**	**Annual Fees**	**Deduction for 24 Paydays**	**Please choose plan Option**
PLAN A	Semi-Private 60,000.00 MBL	8,500.00	354.17	
PLAN B	Regular Private 60,000.00 MBL	11,300.00	470.83	
PLAN C	Semi-Private 80,000.00 MBL	9,000.00	375.00	
PLAN D	Regular Private 80,000.00 MBL	11,400.00	475.00	
PLAN E	Regular Private 100,000.00 MBL	13,000.00	541.67	
PLAN F	Regular Private 150,000.00 MBL	14,000.00	583.33	

* The salary deduction amount represents the total premium rate that is shouldered by the employee. Premium rates may vary from year to year.

Definition of Eligible Dependents:

- Children under legal guardianship 90 days old up to 21 years old or;
- Domestic Partners not exceeding 65 years old

INFORMATION ON ELIGIBLE DEPENDENTS:

Last Name	First Name	MI	Ext. (Jr., II...)	Birth Date (mm/dd/yyyy)	Age	Relationship (Mother/Father/ Sibling)	Sex (M/F)	Civil Status

Guidelines for Enrolling Dependents:

1. I need to submit the following requirements in enrolling my dependents:

Requirements:

Children under legal guardianship – copy of Court Order/Documents of legal guardianship
Domestic Partner - Affidavit of domestic partnership/barangay certification indicating the same residential address for principal and domestic partner
Sibling – copy of birth certificate of sibling, one of my parents, and principal member's birth certificate

2. I understand that upon **change of status** from Single to Married, the Medicard coverage of my same-sex partner and sibling will be cancelled effective the date of my marriage. I may enroll newly eligible dependent in the regular Health Insurance Plan no later than **45** days from date of my marriage.

Requirements:

Spouse - copy of Marriage Certificate

3. I understand that enrolling my extended family members or domestic partner is a commitment for one year. I am aware that I cannot cancel my dependents not until the renewal which is at the end of this contract year.

I certify that the information that I have provided above are true and correct to the best of my knowledge, and have followed the guidelines on dependent enrollment stated above. I understand that my providing any false information will invalidate coverage of all my dependents listed above. I authorize the Company and Medicard to obtain a copy of all pertinent medical information in the course of my dependents' membership in the Plan.

_____ Employee's Signature

_____ Date

_____ Received by OHCD / Date

DEADLINE OF SUBMISSION OF DEPENDENT FORMS IS 8 DAYS FROM YOUR START DATE OF EMPLOYMENT. EMPLOYEE SERVICES (ES) WILL NOT ACCEPT THE FORMS NOT UNLESS ALL DETAILS AND NECESSARY ATTACHMENTS ARE COMPLETE. ALL FORMS GIVEN AFTER THE DEADLINE WILL NO LONGER BE ACCOMODATED. PLEASE MAKE SURE TO HAVE THE ES SPECIALIST SIGN IN YOUR PRE-EMP CHECKLIST TO CERTIFY THAT SHE RECEIVED YOUR HIP FORM. OHCD WILL NOT BE ACCOUNTABLE FOR ANY LOST OR MISPLACED FORMS NOT SUBMITTED DIRECTLY TO THE ES SPECIALIST.