**HPP AD&D BENEFITS ENROLLMENT FORM**

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<th>Name</th>
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**Accidental Death and Dismemberment Insurance**  
*(Combined Insurance Company of America, Policy Number 42713VA)*

This optional insurance allows employees to insure themselves and eligible family members against covered accidents in an amount up to $500,000. Dependents covered under this plan are covered only for a specified percentage of the employee’s elected coverage. (See Plan Booklet for specific details.) Evidence of insurability is never required to enroll in this coverage. Coverage is effective on the first of the month following the date the enrollment form is submitted to the Benefits Department (or on the date it is submitted if it is the first day of the month).

**Select one of the following options:**
- [ ] Employee Only Coverage ($.19 per $10,000 of coverage)
- [ ] Employee and Family Coverage ($.36 per $10,000 of coverage)
- [ ] Waive

**Coverage amount desired:** $____________________________

**Designate at least one Primary and one Contingent Beneficiary (if more than one, state percent of benefit to go to each person):**

- **Primary Beneficiary:** ______________________________ Relationship to Employee: __________________
- **Contingent Beneficiary:** ____________________________ Relationship to Employee: __________________

*(Employee is beneficiary for coverage on family members)*

I have read and understand the information provided. I agree to the terms of the plans selected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize payroll deductions of premiums as required.

Employee Signature: __________________________________________ Date: ______________________

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<th>Benefit Dept Use Only</th>
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<th>Entered By:</th>
<th>QC By:</th>
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