



INSTRUCTIONS: Please fill out the entire form using BLACK ink. Please write neatly using capital letters. When complete, answer the questions at the bottom of the page and sign your name in the signature box.

EMPLOYEE RECORD

Employee Record form fields: Social Security Number, Birth Date, Employee Status, Sex, Disabled, First Name, MI, Last Name, Address 1, Marital Status, Address 2, City, State, Zip, Retirement Date.

Dependent 1 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 2 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 3 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 4 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 5 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 6 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

Dependent 7 form fields: Terminate Coverage?, Social Security Number, Birth Date, Relation, Sex, Student, Disabled, First Name, MI, Last Name.

QUESTIONS

Questions section: Are you or your dependents covered under another healthcare insurance program... Are you or your dependents entitled to benefits from Medicare... Do you access the Internet from home... E-mail address (leave blank if none):

Please return this form to: MILA, 111 Broadway, 5th Floor, New York, NY 10006

Signature box with 'sign here' text.

I verify that the above information is correct.

DATE