CITGO Petroleum Corporation
SALARY BENEFITS ENROLLMENT FORM

(With HMO Area)

NAME FIRST MIDDLE LAST	SOCIAL SECURITY NO.		
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE (OPTIONAL)	WORK PHONE	
POSITION TITLE	HIRE DATE	PERNR	

IMPORTANT ENROLLMENT INFORMATION - READ CAREFULLY

Under the CITGO Medical, Dental, Vision and Life Insurance programs, if you are covered for benefits as an employee, you cannot be covered as a dependent. Eligible children can only be covered by one parent under the Medical, Dental, Vision and Life Insurance programs if both parents are CITGO employees and/or retirees.

In consideration of the above Plan provisions, are you currently married to or the dependent of another CITGO Employee or Retiree?
☐ **Yes** ☐ **No**

If "Yes", please confirm the name and Social Security Number _____

MEDICAL

MEDICAL OPTION (Check Only One)		MEDICAL LEVEL OF COVERAGE (Check Only One)
NETWORK AREA	**NON-NETWORK AREA**	
☐ Exclusive Provider Option (EPO) ☐ Preferred Provider Option (PPO) ☐ High Deductible Health Plan (HDHP) ☐ Aetna HMO **(Must complete Aetna form also)** ☐ WAIVE Coverage	☐ Non-Network Option ☐ WAIVE Coverage **Note: The HDHP is for employees in all network areas.**	☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family

DENTAL

DENTAL OPTION - (Check Only One)	DENTAL LEVEL OF COVERAGE - (Check Only One)
☐ Dental PPO Option ☐ WAIVE Coverage	☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Family

VISION

VISION OPTION - (Check Only One)	VISION LEVEL OF COVERAGE - (Check Only One)
☐ Vision Program ☐ WAIVE Coverage	☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Family

PERSONAL ACCIDENT

ERSONAL ACCIDENT	PERSONAL ACCIDENT LEVEL OF COVERAGE (Check Only One)
Maximum amount allowed is 10 x your Annual Base Salary up to $750,000 and the minimum coverage amount is $10,000 You must elect coverage in multiples of $5,000. Amount of Coverage: $_____	☐ Employee Only ☐WAIVE Coverage ☐ Family

OPTIONAL LIFE INSURANCE

Employee (Check Only One)	Spouse (Complete Only One)	Dependent Child (Check Only One)
☐ 1 x Annual Base Salary ☐ 2 x Annual Base Salary ☐ 3 x Annual Base Salary ☐ 4 x Annual Base Salary ☐ 5 x Annual Base Salary ☐ WAIVE Coverage Statement of Health required if your combined basic and optional life is greater than $1,500,000. Statement of Health required for late enrollment.	You may elect up to 50% of the total amount of your combined Basic Life insurance (1 x Annual Base Salary) and your Optional Life insurance amount. You may elect a minimum of $10,000 up to maximum of $250,000. Elect in multiples of $10,000. Coverage Amount: $_____ ☐ WAIVE Coverage Statement of Health required for amounts elected greater than $30,000. Statement of Health required for late enrollment.	You may elect dependent child coverage for all eligible dependents. **(Check Only One)** ☐ $5,000 / Each Child ☐ $10,000 / Each Child ☐ WAIVE Coverage Statement of Health required for late enrollment.

Dependent Name	Relation to you	Date of Birth	Dependent SSN	Medical	Dental	Vision	Dep Life	Pers Acc
Leslie Example	Spouse	mm/dd/yy	123-45-6789	Y ☒ N ☐	Y ☐ N ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Your elections cannot be changed until the next Annual Election period unless you or any of your eligible dependents experience a qualifying status change event. Requests for coverage changes related to a qualified status change must be made within 31 days of the event and be consistent with the changes permitted under Internal Revenue Code Section 125 Cafeteria Plan rules. More information on qualified status changes can be found outlined in the Summary Plan Description.

My signature below indicates that I have read this enrollment form and the descriptive material on the plans, and that I understand the options available to me. My signature further indicates that I am authorizing regular deductions from my pay on a tax-free basis (where applicable). I understand that my tax-free contributions under these plans are deducted from my pay before federal income, state income (where applicable), and Social Security taxes and that this may slightly reduce my Social Security benefits.

____ ______________________________

Employee Signature **Date**

Please be sure to create a duplicate copy of this signed and dated form by scanning electronically or by using a copy machine so you will have a copy for your records.

THIS SECTION IS FOR BENEFITS DEPARTMENT USE ONLY

STATEMENT OF HEALTH REQUIREMENT REVIEW

Employee Optional	**Spouse Optional**	**Dependent Optional**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Key this amount $__________________	Key this amount $__________________	Key this amount $__________________
Amount pending approval from underwriting $____________________	Amount pending approval from underwriting $____________________	Amount pending approval from underwriting $____________________
Reviewer Initials ____________	Reviewer Initials ____________	Reviewer Initials ____________