

# CITGO Petroleum Corporation HOURLY BENEFITS ENROLLMENT FORM

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	
<input type="checkbox"/> Exclusive Provider Option (EPO) <input type="checkbox"/> Preferred Provider Option (PPO) <input type="checkbox"/> High Deductible Health Plan (HDHP) <input type="checkbox"/> WAIVE Coverage	<input type="checkbox"/> Non-Network Option <input type="checkbox"/> WAIVE Coverage <b>Note: The HDHP is for employees in all network areas.</b>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Family

### DENTAL

DENTAL OPTION - (Check Only One)	DENTAL LEVEL OF COVERAGE - (Check Only One)
<input type="checkbox"/> Dental PPO Option <input type="checkbox"/> WAIVE Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family

### VISION

VISION OPTION - (Check Only One)	VISION LEVEL OF COVERAGE - (Check Only One)
<input type="checkbox"/> Vision Program <input type="checkbox"/> WAIVE Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family

### PERSONAL ACCIDENT

PERSONAL ACCIDENT	PERSONAL ACCIDENT LEVEL OF COVERAGE (Check Only One)
Maximum amount allowed is 10 x your Annual Base Salary up to \$500,000 and the minimum coverage amount is \$10,000. You must elect coverage in multiples of \$5,000.  Amount of Coverage: \$ _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> WAIVE Coverage <input type="checkbox"/> Family

### LIFE INSURANCE

OPTIONAL LIFE	DEPENDENT LIFE
You may elect a combined coverage of 3 times your annual base pay under Pre-Retirement and Post Retirement Life Insurance (you may only elect a maximum of 2X Post-Retirement).	You may elect dependent child coverage for all eligible dependents.
<b>Pre-Retirement Life (Check Only One)</b>  <input type="checkbox"/> 1 x base salary <input type="checkbox"/> 2 x base salary <input type="checkbox"/> 3 x base salary <input type="checkbox"/> Waive Coverage  Statement of Health required for late enrollment.	<b>Dependent Life (Check Only One)</b>  <input type="checkbox"/> \$7,500 for Spouse / \$1,500 Child <input type="checkbox"/> Waive Coverage  Statement of Health required for late enrollment.
<b>Post-Retirement Life (Check Only One)</b>  <input type="checkbox"/> 1 x base salary <input type="checkbox"/> 2 x base salary <input type="checkbox"/> 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	
				Y	<input checked="" type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input checked="" type="checkbox"/>	Y	<input checked="" type="checkbox"/>	Y	<input checked="" type="checkbox"/>
Leslie Example	Employee	mm/dd/yy	123-45-6789	Y	<input checked="" type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input checked="" type="checkbox"/>	Y	<input checked="" type="checkbox"/>	Y	<input checked="" type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input checked="" type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>
		/ /	- -	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>	Y	<input type="checkbox"/>
		/ /	- -	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>	N	<input type="checkbox"/>

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**

Pre-Retirement Life	Post-Retirement Life	Dependent Life
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____