



**Employee Benefit Department**  
**Enrollment/Change Form (Hawaii Locations Only)**

Choose One and Enter Effective Date:

- New Enrollment \_\_\_\_\_
- Add Dependent(s) \_\_\_\_\_
- Delete Dependent(s) \_\_\_\_\_
- Status/Enrollment Change \_\_\_\_\_
- Open Enrollment \_\_\_\_\_
- Other: \_\_\_\_\_

|               |            |                                     |                      |
|---------------|------------|-------------------------------------|----------------------|
| Employee ID # | Location # | Employee Name (Last, First, Middle) | Hire Date (MM/DD/YY) |
|---------------|------------|-------------------------------------|----------------------|

Single     Domestic Partner     Legally Separated     Married     Legal Guardian     Widowed/Divorced

**LIFE AND AD&D INSURANCE BENEFICIARY DESIGNATION:** If you have more than one beneficiary, please complete a "Beneficiary Designation Form."

|                              |                        |                     |               |
|------------------------------|------------------------|---------------------|---------------|
| Beneficiary's Name           | Social Security Number | Relationship to You |               |
| Beneficiary Address (Street) |                        | (City)              | (State) (Zip) |

Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivors. If no beneficiary survives, payments shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. You have the right to change your beneficiary at any time. All changes must be received in writing and will take effect upon receipt.

**MEDICAL PLAN:**  HMSA PPO     HMSA HMO

**DENTAL PLAN:**  Core Dental     Premium Dental     Decline Dental

**LEVEL OF HEALTH COVERAGE: (check all that apply)**     Employee     Spouse     Child(ren)    Please indicate number of children \_\_\_\_\_

Are you covered under another Costco Employee?     Yes     No    If yes, what is their EE # or SSN? \_\_\_\_\_

Are you covering another Costco Employee?     Yes     No    If yes, what is their EE # or SSN? \_\_\_\_\_

**DECLINE MEDICAL AND DENTAL COVERAGE:** Complete and attach the required Decline Coverage Acknowledgment Form. Complete the optional coverages section below for other benefit programs.

If you are electing spouse or dependent coverage, please list your eligible spouse or dependents below. List additional dependents on a separate page. You must provide supporting documentation for your spouse or dependents before their coverage will begin. Please see the reverse side of this form for a list of eligible dependents and the required documentation for each.

| Spouse or Dependent Name | Social Security Number (If available) | Date of Birth | Sex M/F | Relationship to Employee | HMO Provider ID Code |
|--------------------------|---------------------------------------|---------------|---------|--------------------------|----------------------|
| #1                       |                                       |               |         |                          |                      |
| #2                       |                                       |               |         |                          |                      |
| #3                       |                                       |               |         |                          |                      |
| #4                       |                                       |               |         |                          |                      |

Employees, spouses or dependents enrolling or re-enrolling in Costco's medical plans may be subject to pre-existing condition restrictions. Detailed information regarding the pre-existing condition exclusions is included with your enrollment materials.

**OPTIONAL COVERAGES:** Details on each optional coverage listed below are contained in the Highlights Booklet and Summary Plan Description.

Voluntary Hourly STD:     Yes     No    Not available in CA, HI, NJ, NY, RI and PR.

Supplemental AD&D:     Employee Only     Employee and Children     Employee and Family     None

Amount: \_\_\_\_\_ Coverage is available in \$50,000 increments up to \$1,500,000. Any amount in excess of \$250,000 may not exceed 10 times your annual earnings.

Supplemental Life:     Yes     No    (Requires separate application)

Dependent Care Assistance Plan (DCAP):     Yes     No    (Requires separate application)

Health Care Reimbursement Account (HCRA):     Yes     No    (Requires separate application)

**HCRA elections can be made during Annual Open Enrollment only and cannot be changed or stopped during the plan year.**

I agree that my compensation will be reduced by the amounts required to pay for my benefit selections. I understand that deductions for health coverage, HCRA, LTD and DCAP will be withheld on a pre-tax basis, and that all other deductions are withheld post-tax. I understand that my benefit selections (or my decision to decline coverage) and my salary reductions related to my benefits are irrevocable until the end of the year. If I do not modify my elections at [www.costcobenefits.com](http://www.costcobenefits.com) or by calling 1-800-541-6205 by the end of Annual Open Enrollment, I will be treated as having elected for the following year the same benefit selections (or decision to decline coverage) as are then in effect, except for HCRA and DCAP. I must elect to participate in the HCRA and DCAP at each Annual Open Enrollment (typically held in November). If this is my initial enrollment, I understand that if I do not complete and return this Enrollment Form by the 30th day after my first day of eligibility, I will be treated as having elected for the remainder of the year employee-only HMSA HMO health and Core Dental coverage and to pay for such coverage with pre-tax salary reductions. I have read the Summary Plan Description for the Costco Employee Benefits Program and I understand my rights to benefits under the program.

|                      |             |
|----------------------|-------------|
| Employee's Signature | Date Signed |
|----------------------|-------------|

## Make Sure Your Enrollment is Complete!

- When enrolling your family members ...  
 Costco requires you to prove that a family member is eligible before coverage will begin.  
 Copies of the following documentation must be provided:

| Eligible Family Member                         | Document Description   |
|--|--|
| Spouse (opposite sex)                          | State-Certified Marriage Certificate   |
| Benefit-Eligible Costco Employee Family Member | You must provide a Benefit Enrollment form + Decline Coverage Acknowledgment form completed by this Family Member in addition to the other documents required to establish eligibility.  |
| Newborn/Newly Adopted Dependent Child          | You must submit this form along with a state-certified Birth Certificate within 60 days of birth to obtain coverage as of the date of birth. If you do not have the birth certificate, you may submit this form along with a hospital issued record of birth that names the employee as a parent, and then provide the state-certified birth certificate within 90 days of birth. You have 60 days from adoption or placement for adoption to enroll your child. |
| Dependent Child (up to age 19)                 | State-Certified Birth Certificate  |
| Dependent Child (age 19 up to age 23)          | State-Certified Birth Certificate + Proof of full-time student status  |
| Step-Child                                     | State Certified Birth Certificate + Declaration of Plan Eligibility for Step-Child form + marriage certificate + proof of full-time student status for step child age 19 to 22.  |
| Legal Guardian                                 | Declaration of Legal Guardianship and documentation required by the declaration. Proof of full-time student status for child age 19 to 22.   |
| Domestic Partner and Domestic Partner's Child  | Declaration of Domestic Partnership and documentation required by the declaration. Birth Certificates for children of domestic partners + proof of full-time student status if age 19 to 22.   |

- When choosing the "Decline Coverage" option ...

- You must complete and return the Decline Coverage Acknowledgement Form.
- If you do not complete and return this form, you will be treated as having made no election. You will be enrolled in employee-only HMSA HMO and Core Dental.

If you fail to timely provide the required documentation to the Benefits Department or your Location's payroll department, your request to enroll dependents or decline coverage will not be processed. If you have questions, please contact the Benefits Department at 1-800-284-4882. See the Summary Plan Description for details on enrollment and deadlines for enrollment.

