COBRA/Early Retiree Benefits Enrollment/Change Form

Please use pen, print clearly and keep a copy for your records

Section 1 Personal Information

Employee Last Name	First Name		M.
Cell Phone	Social Security Number		Employee ID (optional)
Home Address (Street, Apt.#)	City	State	Zip Code
Home Phone	E-mail Address		

Section 2 Type of Enrollment or Change

☒ Annual Open Enrollment ☐ Qualified Status Change _____

Section 3 Medical, Dental and Vision Coverage

Medical Enter name of Medical Plan you want to enroll in: _____

For Kaiser Members (California) Only Select Group Number: ☐ Kaiser North (8493) ☐ Kaiser South (103926)

If you are dropping a plan, list plan name: _____

Select Coverage Level:

☐ Individual ☐ 2 Person ☐ Individual Plus Domestic Partner* ☐ Family ☐ Waive Coverage

Dental Delta Dental PPO Plus Premier

Select Coverage Level:

☐ Individual ☐ 2 Person ☐ Individual Plus Domestic Partner* ☐ Family ☐ Waive Coverage

Vision Plan Vision Service Plan

Select Coverage Level:

☐ Individual ☐ 2 Person ☐ Individual Plus Domestic Partner* ☐ Family ☐ Waive Coverage

List information for yourself and your eligible dependents. Please Check Box

Name (last, first)	Add/ Cancel	Date of Birth MM/DD/YY	Social Security Number	Relationship Code**	Sex	Medical	Dental	Vision
				SB				

* If you are enrolling a domestic partner, you must contact the HR Service Center at 978-370-3041 or hr.service.center@teradyne.com to obtain an affidavit.

**Relationship Codes: SB - Subscriber SP - Spouse DP - Domestic Partner D - Daughter S - Son OT - Other (must have court order or legal guardianship)

Section 4 For Kaiser Enrollments ONLY

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled through a group that is subject to certain ERISA benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature _____ Date _____

Section 5 All Employees Must Sign

I agree to remit payment to Teradyne on the first of each month for any of the plans I have elected to participate in. Further, if enrolling in a medical plan, I understand that some plans have specific legal terms and conditions which are listed on the back of this form. If my plan is listed, I affirm that I have read the plan's terms and conditions.

Signature _____ Date _____

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Because Testing Matters

Qualifying Status Changes

You have 30 days from the date of the events listed below to submit changes to your benefit plans to your Human Resources department. Any change you make must be consistent with and on account of your change in status. You may be asked to provide proof of the change in status. If you do not submit your form within 30 days of the event, you will not be able to change your elections until the next annual Open Enrollment period.

Code	Qualifying Events
1	Change in your legal marital status (marriage, divorce, annulment)
2	Change in number of dependents (birth, adoption, death of dependent)
3	Change in employment status for you or your spouse (change must result in a gain or a loss of benefit eligibility)
4	Dependent reaches age limit for benefit plan
5	You move into or out of a medical plan service area
6	You commence or terminate adoption proceedings
7	A significant cost increase to one of your health care plans
8	Significant coverage curtailment to one of your health care plans
9	An addition or elimination of a benefit option. This includes the ability to make changes to your Dependent Care Reimbursement account if you experience a change in day care providers, the hours of day care, or a change in the cost as long as the cost change is not imposed by a relative.
10	A change in coverage of spouse or dependent under another employer's plan. This includes the annual open enrollment period for your spouse or dependent.

Blue Cross Blue Shield

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.