



LEGAL PLAN ENROLLMENT FORM



Enrollment Change Coverage Level Date of Family Status Change _____ Drop Coverage

Coverage level may only be changed within 31 days of the occurrence of the family status change.

Member Name (First, Middle, Last) _____

Social Security Number _____

Home Street Address _____

City, State, ZIP _____

Home Phone _____

Union Name _____

Agency Name _____

Work Address _____

Employee ID Number _____

Work Phone _____ Alternate Phone Number (Not Work) _____

LEVEL OF COVERAGE

SINGLE \$13.40 a month

FAMILY \$16.45 a month

I authorize the State of Ohio to take the premium for the legal service plan coverage I select once a month from my pay. Coverage will begin under the plan July 1, 2010. I understand that my election will remain in force until I change or drop my coverage, and that I may only make changes/drops during open enrollment for the following July 1 coverage effective date. My coverage will also end if I am no longer an eligible Trust member or I leave State employment, once payroll deductions stop.

Signature

Date

AFTER SIGNING AND DATING THE FORM, MAIL IT TO HYATT.
Hyatt Legal Plans • Eaton Center • 1111 Superior Avenue • Suite 800 • Cleveland, Ohio 44114-2507

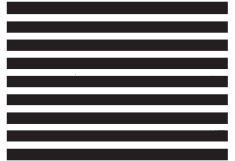
Group legal service plans are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio.

To mail, fold this end down first.

FOLD HERE



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 5388 CLEVELAND, OH

POSTAGE WILL BE PAID BY ADDRESSEE

Hyatt Legal Plans, Inc.
Attention: Director of Administration
1111 Superior Ave. E., Suite 800
Cleveland, OH 44114-9584



FOLD HERE

Second, fold this end up, and place tape on edge, in center.
Bottom fold should be smooth and not taped.