



SCHEDULE "B"
EMPLOYEE HANDBOOK

By signing this form, I acknowledge that I have received a copy of the Employee Handbook of Multipoint Wireless LLC. I understand that it contains important information about the Company's policies, that I am expected to read the Employee Handbook and familiarize myself with its contents, and that the policies in the Employee Handbook apply to me. I understand that nothing in the Employee Handbook constitutes a contract or promise of continued employment and that the Company may change the policies in the Employee Handbook from time to time.

By signing this form, I acknowledge that my employment at Multipoint Wireless LLC is *at will*. I understand that I have the right to end the employment relationship at any time and for any reason, with or without notice, with or without cause, and that the Company has the same right. I acknowledge that neither the Company nor I have entered into an employment agreement for a specified period of time, that only an officer of Multipoint Wireless LLC may make any agreement contrary to the at-will policy, and that any such agreement must be in writing, signed by myself and an officer of Multipoint Wireless LLC.

Employee's Signature – _____
Date – _____
Employee's Name – _____

SCHEDULE "C"
SAFETY MANUAL

I acknowledge that I have read the Multipoint Wireless LLC Safety Manual.

Employee's Signature – _____
Date – _____
Employee's Name – _____

SCHEDULE "D"
NON-DISCLOSURE / NON-COMPETENCY / NON-SOLICITATION AGREEMENT

I have carefully read this Confidentiality & Non-Disclosure / Non-Competency / Non-Solicitation agreement and understand its contents. I acknowledge that I have had the opportunity to consult with an attorney or individual from whom I wished to obtain advice concerning this agreement before signing it. I agree this agreement is fair, just and reasonable under the circumstances and I am executing this agreement under free will and voluntarily.

Employee's Signature – _____
Date – _____
Employee's Name – _____

MULTIPOINT
WIRELESS LLC

2549 Eastbluff Dr, Suite 474,
Newport Beach, CA 92660



*****IMPORTANT NOTICE*****

FIRST PAYCHECK IS LIVE

If you select this option, your paycheck will be mailed with no guarantee that it will arrive on Friday. We are unable to track the paycheck.

Send my first paycheck via regular mail to:

OR

Send my first paycheck via overnight delivery for a \$50 charge to be deducted out of my paycheck to:

Employee Signature -

Date -

Employee Name -



DIRECT DEPOSIT AUTHORIZATION FORM

(TO BE COMPLETED BY THE EMPLOYEE)

Employee Name as per bank records _____	Telephone # _____ - _____ - _____
Complete Address as per bank records _____	Last 4 digits of SSN # XXX - XXX - _____

CERTAIN ACCOUNTS MAY HAVE RESTRICTIONS ON DEPOSITS AND WITHDRAWALS. CHECK WITH YOUR BANK FOR MORE INFORMATION.

<u>BANK ACCOUNT # 1</u>	<u>BANK ACCOUNT # 2</u>	<u>BANK ACCOUNT # 3</u>
BANK NAME _____	BANK NAME _____	BANK NAME _____
Account Type (check one) <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account Type (check one) <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account Type (check one) <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account
I wish to deposit (check one) <input type="checkbox"/> Remainder of Net Pay <input type="checkbox"/> _____ % of Net <input type="checkbox"/> Specific Amount \$ _____ .00	I wish to deposit (check one) <input type="checkbox"/> Remainder of Net Pay <input type="checkbox"/> _____ % of Net <input type="checkbox"/> Specific Amount \$ _____ .00	I wish to deposit (check one) <input type="checkbox"/> Remainder of Net Pay <input type="checkbox"/> _____ % of Net <input type="checkbox"/> Specific Amount \$ _____ .00
Attach one of the following (check one) <input type="checkbox"/> Voided check with name imprinted (no starter checks) <input type="checkbox"/> Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number) <input type="checkbox"/> Bank letter or specification sheet (the signature of your local bank representative MUST be included)	Attach one of the following (check one) <input type="checkbox"/> Voided check with name imprinted (no starter checks) <input type="checkbox"/> Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number) <input type="checkbox"/> Bank letter or specification sheet (the signature of your local bank representative MUST be included)	Attach one of the following (check one) <input type="checkbox"/> Voided check with name imprinted (no starter checks) <input type="checkbox"/> Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number) <input type="checkbox"/> Bank letter or specification sheet (the signature of your local bank representative MUST be included)

I hereby certify that I am the accountholder of the account(s) mentioned above. I authorize Multipoint Wireless LLC ("the Company") to make direct deposits into the account(s) mentioned above and to initiate adjustments, if necessary, for any deposits made in error into the account(s) mentioned above. This authorization shall remain in effect until I give a written notification of any change in my financial institution(s) and/or account number(s) mentioned above.

Employee Signature _____
 Employee Name _____
 Date Signed _____

*****You MUST attach supporting documents for every bank account entered above*****



ADDENDUM TO DIRECT DEPOSIT AUTHORIZATION FORM

(TO BE COMPLETED BY THE EMPLOYEE)

Employee Name as per bank records	Telephone #
_____	_____ - _____ - _____
Complete Address as per bank records	Last 4 digits of SSN #
_____	XXX - XXX - _____

CERTAIN ACCOUNTS MAY HAVE RESTRICTIONS ON DEPOSITS AND WITHDRAWALS. CHECK WITH YOUR BANK FOR MORE INFORMATION.

<p><u>BANK ACCOUNT # 4</u></p> <p>BANK NAME _____</p> <hr/> <p>Account Type (check one)</p> <p><input type="checkbox"/> Checking Account</p> <p><input type="checkbox"/> Savings Account</p> <p>I wish to deposit (check one)</p> <p><input type="checkbox"/> Remainder of Net Pay</p> <p><input type="checkbox"/> _____ % of Net</p> <p><input type="checkbox"/> Specific Amount \$ _____ .00</p> <p>Attach one of the following (check one)</p> <p><input type="checkbox"/> Voided check with name imprinted (no starter checks)</p> <p><input type="checkbox"/> Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)</p> <p><input type="checkbox"/> Bank letter or specification sheet (the signature of your local bank representative MUST be included)</p>	<p><u>BANK ACCOUNT # 5</u></p> <p>BANK NAME _____</p> <hr/> <p>Account Type (check one)</p> <p><input type="checkbox"/> Checking Account</p> <p><input type="checkbox"/> Savings Account</p> <p>I wish to deposit (check one)</p> <p><input type="checkbox"/> Remainder of Net Pay</p> <p><input type="checkbox"/> _____ % of Net</p> <p><input type="checkbox"/> Specific Amount \$ _____ .00</p> <p>Attach one of the following (check one)</p> <p><input type="checkbox"/> Voided check with name imprinted (no starter checks)</p> <p><input type="checkbox"/> Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)</p> <p><input type="checkbox"/> Bank letter or specification sheet (the signature of your local bank representative MUST be included)</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

I hereby certify that I am the accountholder of the account(s) mentioned above. I authorize Multipoint Wireless LLC ("the Company") to make direct deposits into the account(s) mentioned above and to initiate adjustments, if necessary, for any deposits made in error into the account(s) mentioned above. This authorization shall remain in effect until I give a written notification of any change in my financial institution(s) and/or account number(s) mentioned above.

Employee Signature _____

Employee Name _____

Date Signed _____

*****You MUST attach supporting documents for every bank account entered above*****

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on www.irs.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
	For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; text-align: center;">2012</div>
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	6 Additional amount, if any, you want withheld from each paycheck	5 _____ 6 \$ _____
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$5,950 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter “-0-”	7	\$ _____
8	Divide the amount on line 7 by \$3,800 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3”	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____
Note. If line 1 is less than line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



2-50 Existing Small Group Employee Addition Application

For adding new employees and their eligible dependents to existing coverage

Employee Application

Small Group Services

Anthem Blue Cross

P.O. Box 9062

Oxnard, CA 93031-9062

anthem.com/ca

Anthem Blue Cross offers: Premier PPO plans, PPO Copay plans, High Deductible EPO, Saver HMO, Classic HMO, HMO 100%, Select HMO, Saver HMO, Classic HMO, HMO 100%, Dental Net and Dental SelectHMO.

Anthem Blue Cross Life and Health Insurance Company offers: Basic PPO, Saver PPO, Solution plans, PPO Copay GenRx, Element Hospital plans, HIA plans, Lumenos HIA Plus 750, Lumenos HIA Plus 500, Lumenos HSA (80/50) plans, Lumenos (100/70) plans, PPO 3500, PPO 2400, Advantage PPO; all dental products except Dental Net and Dental SelectHMO; Life and AD&D plans.

INSTRUCTIONS

1. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. Type or print clearly using blue or black ink.

MEDICAL Group no. 3 | 7 | 1 | 9 | 9 | 7

1 COVERAGE - Please verify with your employer which plans are available. DENTAL/VISION GROUP 4 9 4 3 3 6

A. MEDICAL COVERAGE SELECTION - Check only one Medical Plan:

- | | | | | |
|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Basic PPO | <input checked="" type="checkbox"/> Lumenos HSA 2000 (100/70) | <input checked="" type="checkbox"/> Premier PPO \$10 Copay | <input type="checkbox"/> Solution 5000 PPO | <input checked="" type="checkbox"/> Saver HMO |
| <input checked="" type="checkbox"/> Saver PPO | <input checked="" type="checkbox"/> Lumenos HSA 3000 (100/70) | <input checked="" type="checkbox"/> Premier PPO \$20 Copay | <input checked="" type="checkbox"/> High Deductible EPO | <input checked="" type="checkbox"/> Saver \$20 HMO |
| <input checked="" type="checkbox"/> PPO \$25 Copay GenRx | <input checked="" type="checkbox"/> Lumenos HSA 1500 (80/50) | <input checked="" type="checkbox"/> Premier PPO \$30 Copay | <input checked="" type="checkbox"/> HMO 100% | <input checked="" type="checkbox"/> Saver \$30 HMO |
| <input type="checkbox"/> PPO \$35 Copay GenRx | <input checked="" type="checkbox"/> Lumenos HSA 2500 (80/50) | <input checked="" type="checkbox"/> Power Health Fund 500 | <input checked="" type="checkbox"/> HMO \$10-100% | <input checked="" type="checkbox"/> Saver \$40 HMO |
| <input type="checkbox"/> PPO \$45 Copay GenRx | <input type="checkbox"/> Lumenos HSA 3500 (80/50) | <input checked="" type="checkbox"/> Power Health Fund 750 | <input checked="" type="checkbox"/> HMO \$25-100% | <input checked="" type="checkbox"/> Select HMO |
| <input checked="" type="checkbox"/> PPO \$20 Copay | <input checked="" type="checkbox"/> Lumenos HIA 500 | <input checked="" type="checkbox"/> PPO 2400 (HSA-Compatible) | <input checked="" type="checkbox"/> Classic HMO | <input checked="" type="checkbox"/> Select \$25 HMO |
| <input type="checkbox"/> PPO \$30 Copay | <input checked="" type="checkbox"/> Lumenos HIA 750 | <input checked="" type="checkbox"/> PPO 3500 (HSA-Compatible) | <input checked="" type="checkbox"/> Classic \$20 HMO | <input checked="" type="checkbox"/> Select \$35 HMO |
| <input type="checkbox"/> PPO \$40 Copay | <input checked="" type="checkbox"/> Lumenos HIA Plus 3000 | <input type="checkbox"/> Solution 2500 PPO | <input type="checkbox"/> Classic \$30 HMO | <input checked="" type="checkbox"/> Elements Hospital Preferred |
| <input checked="" type="checkbox"/> Lumenos HSA 1500 (100/70) | <input checked="" type="checkbox"/> Advantage PPO \$25 Copay | <input type="checkbox"/> Solution 3500 PPO | <input type="checkbox"/> Classic \$40 HMO | <input checked="" type="checkbox"/> Elements Hospital Plus |
| | | | | <input checked="" type="checkbox"/> Elements Hospital |
| | | | | <input type="checkbox"/> Other: _____ |

If selecting an HMO, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA).

If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list by number below in Section 3A.

HMO plan PMG or IPA Medical Office Number:

Are you currently a patient of this facility? Yes No

B. DENTAL COVERAGE SELECTION - (if group has elected Dental Coverage) - Check only one Dental Plan:

- | | | |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Dental Blue Silver <u>100-80 100 200 300</u> | <input type="checkbox"/> Basic Option PPO* | <p>You must select a dental office number for the following plans:</p> <p><u> </u> Dental Office No.</p> <input type="checkbox"/> Dental Net
<input type="checkbox"/> Dental SelectHMO |
| <input type="checkbox"/> Dental Blue Silver Plus <u>100-80 100 200 300</u> | <input type="checkbox"/> Standard Option PPO* | |
| <input type="checkbox"/> Dental Blue Gold <u>100-80 100 200 300</u> | <input type="checkbox"/> High Option PPO* | |
| <input type="checkbox"/> Dental Blue Gold Plus <u>100-80 100 200 300</u> | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Dental Blue Platinum <u>100-80 100 200 300</u> | *Fee-for-service dental coverage is substituted if the member is outside of PPO dental service area. | |
| <input type="checkbox"/> Dental Blue Platinum Plus <u>100-80 100 200 300</u> | | |

Voluntary Dental Coverage

- PPO Dental Plan**
- Dental Saver SelectHMO - You must select a dental office number

C. VISION Yes No Blue View Blue View Plus

D. OPTIONAL DEPENDENT LIFE INSURANCE - (Available only if offered by employer.) Yes No

E. SUPPLEMENTAL LIFE INSURANCE - (Available only if offered by employer.) Yes No Amount: \$15,000 \$25,000 \$50,000 \$100,000

2 EMPLOYEE INFORMATION - Must be completed by employee.

Family addition New hire COBRA Cal-COBRA* COBRA/Cal-COBRA Effective Date:

Late enrollment Other

*Cal-COBRA applicants must submit first month's premium.

Last name		First name		M.I.	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner (DP)		Social Security or ID no.		
Home address (P.O. box not acceptable unless rural P.O.)				Apt no.	# of dependents including spouse*		Spouse/DP Social Security or ID no.		
City				State	ZIP code		Home phone no. ()		
Hire date (MM/DD/YY)		Employer name MULTIPOINT WIRELESS LLC		Occupation/Job title		<input type="checkbox"/> Part time <input type="checkbox"/> Full time		# of hours worked per week	
Business phone no. ()		Salary (required) \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Life insurance beneficiary = last name, first, M.I. - - - NOT APPLICABLE - - -				Relationship - - - N.A. - - -	

Language choice (optional) English Spanish Chinese Korean

*Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.



3 EMPLOYEE / DEPENDENT INFORMATION – *List yourself and **only those eligible dependents who are enrolling***

Social Security or ID no.

Spouse/DP Social Security or ID no.

An eligible “dependent” is an employee’s lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee’s spouse who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse from the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full time students. Anthem Blue Cross requires written proof of student status annually.

If spouse’s last name is different from yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of marriage: _____ Date of Adoption: _____

3A. HMO only - IPA
 If you select an IPA you must choose a primary care physician for each member of your family.

Sex	Last Name	First Name	MI	Height	Weight	Disabled?	Birthday Mo. Day Year	Primary Care Physician No.
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee					<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/DP*					<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

4 COVERAGE DECLINATION – *To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents. Proof of coverage may be required.*

- A. Health Plan coverage declined for:
 Myself Spouse/DP*
 Child(ren)
- B. Dental coverage declined for:
 Myself Spouse/DP*
 Child(ren)
- C. Vision coverage declined for:
 Myself Spouse/DP*
 Child(ren)
- ~~D. Life insurance declined for:
 Myself Spouse/DP*
 Child(ren)~~

Reason for declining coverage: (Check one)

- Covered by spouse’s group coverage -
 Carrier name and ID number: _____
- Covered by Anthem Blue Cross Individual Policy
- Spouse covered by employer’s group medical coverage -
 Carrier name: _____
- Covered by Tricare
- Enrolled in any other insurance carrier plan -
 Carrier name: _____
- Medicare
- Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

X _____
 Signature if declining coverage for employee/dependent(s) Date (Month/Day/Year)

*Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.

Social Security or ID no.									

6 AUTHORIZATION - Continued

Please Read Carefully - **Signature Required**

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

All signatures and dates below are required if applying for coverage.

Signature of employee	Date (MM/DD/YY)
X	

see above

After completion, sign Authorization and submit application to your employer. *Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.*

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

