EMPLOYEE ELECTION FORM

Alliance Coal, LLC & Affiliates
Alliance Coal Health Plan
Alliance Coal Dental, Vision, and Flexible Benefits Plan
Alliance Coal Life and Disability Plan

Employee Number: _____

Date of Hire: _____

1. Type of Enrollment

☐ Annual Enrollment ☐ Status Change ☐ Beneficiary Change ☐ Rehire ☐ Other _____
☐ Name Change ☐ Change in Life Insurance ☐ Cancel Coverage ☐ New Hire

2. General Employee Information

Last Name	First Name	Middle Initial	Date of Birth

Street Address	City	State	Zip	County

Telephone Number	Marital Status	Gender	Social Security Number
☐ Home ☐ Cell ( )	☐ Married ☐ Divorced ☐ Single ☐ Widow	☐ Male ☐ Female	

3. Health Plan Coverage Elections

I elect the following Health Plan Coverage (includes Medical, Prescription, Vision, Dental):	☐ Single Coverage ☐ Family Coverage ☐ Waive Coverage
I elect to opt out of the following:	☐ Vision ☐ Dental

4. Employee and Dependents (For Health Coverage)

All dependent children under age 26 must be listed below. Disabled Dependents (DD – unmarried children over age 26 who are incapable of self-sustaining employment because of physical or mental disability and who are dependent on you for maintenance and support) must be listed below and attach a physician's statement.

	Name (Last, First, Middle Initial)	Social Security Number	Gender	Date of Birth	DD Yes or No	(A)dd D(rop)	Effective Date
Employee					N/A		
Spouse					N/A		
Child					☐Y ☐ N		
Child					☐Y ☐ N		
Child					☐Y ☐ N		
Child					☐Y ☐ N		

5. Beneficiary Designation for Basic Life/Employee Life/AD&D Elections

(If you have listed more than one Primary beneficiary and have not indicated the percentage of benefit payable to each beneficiary, the benefit will be divided equally between the beneficiaries listed. A Contingent beneficiary will receive the benefit if your named Primary beneficiary(ies) die before the insured dies. If additional space is needed to list beneficiary information, please attach a separate form.)

	Name (Last, First, Middle Initial)	Date of Birth	Relationship	Social Security Number	Benefit % (=100%)
Primary					
Primary					
Contingent					
Contingent					

6. Employee Initials Below

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7. Basic Life Insurance – The Company provides two times (2x) your annual base pay at no charge to you.

8. Optional Employee Life Insurance Elections (After-Tax)

- To supplement your company paid Basic Life Insurance, you may elect to purchase Optional Life Insurance.
- Elections for Optional Life Insurance over 3x annual base wage will be subject to Evidence of Insurability.
- Elections for Optional Life Insurance is limited to $1,000,000 (when combined with Basic Life coverage)

Choose one Option below:

☐ 1x annual base wage ☐ 3x annual base wage ☐ 5x annual base wage ☐ 7x annual base wage ☐ No Coverage
☐ 2x annual base wage ☐ 4x annual base wage ☐ 6x annual base wage ☐ 8x annual base wage

9. Optional Employee AD&D (Accidental Death & Dismemberment) Elections (Pre-Tax)

- Employee AD&D coverage maximum: $2,000,000

Choose one Option below:

☐ 1x annual base wage ☐ 3x annual base wage ☐ 5x annual base wage ☐ 7x annual base wage ☐ No Coverage
☐ 2x annual base wage ☐ 4x annual base wage ☐ 6x annual base wage ☐ 8x annual base wage

10. Spouse Life Insurance Elections (After-Tax)

- Spouse Life coverage maximum: may not exceed 50% of Employee's combined Basic and Optional Life coverage.
- Elections over $50,000 will be subject to Evidence of Insurability.
- (Note: Optional Employee Life Insurance must be elected in order to enroll in Spouse Life Insurance.)

Choose one Option below:

☐ $10,000 ☐ $50,000 ☐ $100,000 ☐ $200,000 ☐ No Coverage
☐ $25,000 ☐ $75,000 ☐ $150,000 ☐ $250,000

Spouse Name (Last, First, Middle Initial)	Social Security No	Date of Birth

11. Spouse AD&D (Accidental Death & Dismemberment) Elections (Pre-Tax)

- Spouse AD&D coverage maximum: lesser of $250,000 or 100% of employee coverage.
- (Note: Optional Employee AD&D Insurance must be elected in order to enroll in Spouse AD&D Insurance.

Choose one Option below:

☐ $10,000 ☐ $50,000 ☐ $100,000 ☐ $200,000 ☐ No Coverage
☐ $25,000 ☐ $75,000 ☐ $150,000 ☐ $250,000

12. Dependent (Child) Life Insurance Elections (After-Tax)

- Dependent (Child) Life Insurance coverage for child(ren) up to age 21. If more space is needed, please list on a separate page.
- (Note: Optional Employee Life Insurance must be elected in order to enroll in Dependent (Child) Life Insurance.)

Choose one Option below:

☐ $4,000 ☐ $10,000 ☐ No Coverage

Dependent (Child) Name (Last, First, Middle Initial)	Social Security No	Date of Birth

13. Enrollment Agreement

By my signature to this Enrollment Agreement (below), I request the coverage for which I am eligible and have elected on this form. I agree to pay any required contributions pursuant to the terms of the Plan(s) named above. I also authorize all applicable reductions from my compensation in payment of any required contributions on a pre-tax basis. I understand that any material misstatements, misrepresentations or omissions on this form may result in any Plan coverage being void as of its effective date with no benefits payable. I understand that all coverage elected pursuant to this form will be governed by the terms of the applicable Plan.

I understand that the reduction in my compensation authorized pursuant to this Enrollment Agreement will be in addition to any reductions under other agreements or benefits plans.

I understand that I cannot change or revoke my Plan enrollment election until the next open enrollment period, unless a mid-year change in status event (described in the summary for each Plan) occurs that lets me cancel or change my election mid-year, and I timely elect such change in writing on forms provided by the Plan Administrator.

I understand and agree that if I receive any payments of benefits in excess of what is provided by any of the Plans, by mistake or otherwise, I must repay the affected Plan.

I understand that the amount of my required contribution for coverage (and corresponding compensation reduction) is subject to change, and that the Plan Administrator may change or cancel the amount of my compensation reduction in accordance with the applicable terms of the Plans, in its sole discretion and to the extent it deems appropriate for compliance with applicable law or the terms of such Plan(s). My signature to this Enrollment Agreement (below) affirms that all information and statements provided on this form are accurate and complete to the best of my knowledge and belief.

Employee's Signature		Date	
Benefits Administrator – Confirm Receipt		Date	