2020 SUPPLEMENTAL EMPLOYEE BENEFIT ENROLLMENT APPLICATION APPENDIX

(PLEASE PRINT)

TYPE OF ELECTION:

☐ New hire

☐ Change in status, due to (check one):

- ☐ Marriage
- ☐ Dependent eligibility change
- ☐ Loss of coverage under another health plan
- ☐ Enrollment period under another plan
- ☐ Employment status change
- ☐ Birth, adoption, legal guardian/foster child placement
- ☐ Change in work schedule
- ☐ Significant change in another plan
- ☐ Termination of domestic partnership
- ☐ Dependent moves to the United States from another country
- ☐ Day Care FSA change in need
- ☐ Domestic partner declaration
- ☐ Change in residence or work site
- ☐ Change of life insurance beneficiary only
- ☐ Divorce
- ☐ Death
- ☐ Court Order

☐ Rehire

COVERAGE EFFECTIVE DATE:

New Hire & Rehire: Date of hire or rehire is: _____

Change in Status: Date of the change in status is: _____

Coverage Effective Date (for myHR use only): _____

Note: Please provide proof of eligibility or status change (e.g., marriage certificate, last year's federal tax form, birth certificate, baby bracelet, baby hospital footprints, adoption papers, court document, divorce decree, loss of coverage verification, declaration or termination of domestic partnership, etc.)

EMPLOYEE INFORMATION:

Employee Name (First, MI, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Date of Hire (mm/dd/yy)
Street Address	**City and State**	**Zip Code**	**Gender (M/F)**

Critical Illness - Critical Events:

Critical Illness Insurance provides you with extra cash in the event of a cancer diagnosis or critical illness (such as a heart attack, stroke, or end-stage kidney disease). CriticalEvents℠ is designed to come to the rescue of those budget-conscious families by helping pay the costs associated with the initial occurrence after the effective date of a heart attack, stroke, cancer or other serious illness as defined in the policy. Benefits are also available for your spouse and eligible children. Their benefit amount will be 50% of the benefit you elect. Any eligible children of two Stryker employees may be covered as dependents by only one parent. This is a brief summary of CriticalEvents℠ Critical Illness Insurance, underwritten by

Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPCI0500, CCCI0500 and CECI05PA. Forms and numbers may vary. benefits may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Accident - Accident Advance:

Accident Insurance pays you a benefit in the event you or your covered family members are injured in an accident. Accident insurance pays benefits you can use for medical bills and other out-of-pocket expenses – or for any other purpose, including paying your mortgage or other bills. Your medical benefits may not take care of all of the added expenses you'll have after an accident. Benefits are also available to your spouse/declared domestic partner and eligible children. If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent. This is a brief summary of AccidentAdvance®, Accident Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy form series CPACC100 and CCACC100. Forms and form numbers may vary. This coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Hospital Indemnity - Hospital Select II:

Hospital Indemnity Insurance pays you a benefit in the event you or a covered family member is hospitalized. Benefits can be paid for hospital admission, inpatient hospital stays, and intensive care stays. Hospital Select II Hospital Indemnity Insurance policy offers your employees another source of funds when they encounter unexpected out of pocket expenses – extra money they can use in any way they need it. The policy pays a specified amount for each day a covered person is confined to the hospital. Benefits are also available to your spouse/declared domestic partner and eligible children. If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent. This is a brief summary of Hospital Select® II Group Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA. Policy Form Series CPGHI400 and CCGHI400. Forms and form numbers may vary. benefits may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details. THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH benefits UNDER THE FEDERAL AFFORDABLE CARE ACT

Please visit the Total Rewards site at https://totalrewards.stryker.com/Health/Supplemental-Health-Benefits for detailed coverage and premium information.

Plan Coverage Option	Select One
Critical Illness Insurance with Transamerica Life Insurance Company	
Employee Only	
Employee + Child/Children	
Employee + Spouse /Declared Domestic Partner/Family	
Accident Insurance with Transamerica Life Insurance Company	
Employee Only	
Employee + Child(ren)	
Employee + Spouse/Declared Domestic Partner	
Employee + Family	
Hospital Indemnity Insurance with Transamerica Life Insurance Company	
Employee Only	
Employee + Spouse/Declared Domestic Partner	
Employee + Child(ren)	

Employee + Family	

SUPPLEMENTAL HEALTH PLAN DEPENDENT ENROLLEES (skip this section if you do not want to enroll your spouse/domestic partner or dependents in the supplemental health plans):

List all dependents that you wish to enroll or drop from the supplemental health plans. Proof of eligibility is required. If you are enrolling a qualified declared domestic partner contact the myHR Team to obtain the necessary paperwork. Please note that dependents can only be enrolled if you are also enrolled in the plan.

☐ **Adding Enrollee(s)** ☐ **Deleting Enrollee(s)**

First Name	MI	Last Name	Social Security Number (Required)	Relationship (See Codes Below)	Date of Birth (mm/dd/yy)	Gender (M/F)	Critical Illness Coverage (Y/N)	Accident Coverage (Y/N)	Hospital Indemnity Coverage (Y/N)

Relationship Codes: **B** – Spouse **C** – Son, Stepson, Legal Guardian/Foster Son **D** – Daughter, Stepdaughter, Legal Guardian/Foster Daughter
E – Declared Domestic Partner **F** – Declared Domestic Partner's Son **G** – Declared Domestic Partner's Daughter **H** – Disabled Son **I** – Disabled Daughter

CRITICAL ILLNESS BENEFICIARY INFORMATION
Coverage purchased for your spouse/domestic partner or dependent child will pay a benefit to you in the event of the death of your spouse/domestic partner or dependent child.

PRIMARY BENEFICIARY			
Name	**Relationship**	**Date of Birth**	**Percentage of Benefit** (Must Equal 100%)
SECONDARY BENEFICIARY (IF PRIMARY BENEFICIARY NOT LIVING)			
Name	**Relationship**	**Date of Birth**	**Percentage of Benefit** (Must Equal 100%)

EMPLOYEE ACKNOWLEDGEMENT (signature is REQUIRED for ALL EMPLOYEES completing the enrollment form):

Read the following statements carefully. These are important declarations and required notices that you are agreeing to by completing the electronic enrollment process. By submitting this application, I confirm that I have read and understand the representation statement, fraud warning, and conditions for coverage becoming effective as set forth below.

ELIGIBILITY

I confirm that I understand and agree to the terms below:

a) I am actively at work on a full time basis and able to perform the regular duties of my occupation on the date of enrollment;

b) No proposed insured is disabled; and

c) No proposed insured is covered by any Title XIX program (i.e., Medicaid)*.

*c) does not apply to residents of AZ, CO, KS, KY, NC, OR, SC, or VA.

STATEMENTS AND AGREEMENTS

I acknowledge that I received an Outline of Coverage describing the insurance for which I am applying.

The insurance you are applying for is supplemental insurance and is not a substitute for major medical coverage. Residents of CA, GA, MA, MN, NJ, and VT cannot apply for supplemental insurance unless they have comprehensive medical coverage. Residents of these states should remove any proposed insured that does not have comprehensive medical coverage before completing the enrollment process.

I understand that coverage will take effect only if my enrollment is approved by the Insurer and the first month's premium has been received by the Insurer, provided I meet any eligibility and coverage effective date requirements listed in the policy/certificate.

Any person who knowingly and with intent to defraud an insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have committed a fraudulent insurance act, which is a crime and may subject such person to criminal and/or civil penalties.

THE INSURANCE YOU ARE APPLYING FOR PROVIDES LIMITED BENEFITS. IF ACCEPTED FOR COVERAGE, READ YOUR POLICY/CERTIFICATE CAREFULLY.

I hereby request the coverage that I have elected and hereby authorize Stryker to deduct the required employee contributions from my earnings. I acknowledge that my supplemental Critical Illness rates, if this plan is elected, will increase in accordance with the age banding premium schedule. I acknowledge that if I take an unpaid leave of absence from my position, my premiums will be collected from my first paycheck(s) upon my return to work. I further acknowledge that changes in these elections can be made only in the event of a qualified status change or during annual enrollment.

By signing this, you certify that all of the information is correct and accurate. Failure to provide accurate information may result in denial of benefits and other disciplinary action up to and including termination of employment.

Employee Signature: _____ Date: _____