



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) _____

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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, 2008. 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 BY May 16, 2008.
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.