

## 2010 Long Term Disability Benefits Change Form

You will remain enrolled in the health care option(s) in which you are currently enrolled at your current coverage level (Self, Self+1, Self+2 or more), unless you return this form by November 20, 2009 with any changes. You can only change health or dental coverage if you are already enrolled for that coverage. **Note: if you chose to drop coverage for any benefits you currently have, you will NOT be able to re-enroll at a later date.**

710 <small>9-digit Employee EIN starting with 710</small>				
<small>Last Name</small>			<small>First Name</small>	
<small>Address (Street + Apt/Unit #)</small>			<small>Employee Social Security Number</small>	
<small>City/State/Zip Code</small>			<small>Date of Birth</small>	
			<small>Telephone Number (incl. area code)</small>	

<b>A</b>	<input type="checkbox"/> <b>Change to current coverage</b>	<b>Effective Date:</b> January 1, 2010
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	MEDICAL COVERAGE <small>(select one of the medical options below and the type of coverage)</small>	DENTAL COVERAGE <small>(select type of coverage)</small>	VISION COVERAGE <small>(select type of coverage)</small>
<b>B</b>	<input type="checkbox"/> Core Option <input type="checkbox"/> Account-Based Option <input type="checkbox"/> Traditional Option  <input type="checkbox"/> Self <input type="checkbox"/> Self plus 1 <input type="checkbox"/> Self plus 2 or more <input type="checkbox"/> Decline Medical	<input type="checkbox"/> The McGraw-Hill Companies Dental Plan <input type="checkbox"/> The DMO Dental Plan <input type="checkbox"/> Decline Dental <input type="checkbox"/> Self <input type="checkbox"/> Self plus 1 <input type="checkbox"/> Self plus 2 or more	<input type="checkbox"/> Yes <input type="checkbox"/> Decline Vision <input type="checkbox"/> Self <input type="checkbox"/> Self plus 1 <input type="checkbox"/> Self plus 2 or more

**Dependent information:** Be sure all of your dependents are eligible for coverage. Visit [www.mcgrawhillbenefits.com](http://www.mcgrawhillbenefits.com) for eligibility information or call the Human Resources Service Center at 1-888-THE-HRSC (1-888-843-4772).

	Specify last name if different than yours <small>Last Name, First, Middle Initial</small>	Date of Birth <small>mm/dd/yyyy</small>	Gender	Relationship	Social Security #	Medical	Dental	Vision
<b>C</b>	Employee		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Spouse (or other qualified adult dependent)		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependent*		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependent*		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependent*		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependent*		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Dependents – if totally disabled prior to age 23, attach proof of disability for eligibility review

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_