

SALARIED

BENEFITS CHANGE FORM

Reason for Change (check below)

<input type="checkbox"/> Marriage	<input type="checkbox"/> Loss of Employment
<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Gain of Employment
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Employment Status (part-time to full-time or vice versa)
<input type="checkbox"/> Death	<input type="checkbox"/> Other _____
<input type="checkbox"/> Beneficiary Change	

Date Change Occurred (Month/Day/Year) ____/____/____

Part A: Employee Information

Name (Please Print)		Social Security #		
Address	City	State	Zip	Daytime Phone # ()

For each benefit, place an "X" in the box for the **NEW** benefit level and coverage you want

Part B: Change your Benefit Plan or Coverage

MEDICAL PLAN	Option: <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1500 Deductible <input type="checkbox"/> HMO (you must also complete an HMO application) <input type="checkbox"/> No Medical Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + 2 or More Dependents		
DENTAL PLAN	Option: <input type="checkbox"/> \$25 Deductible (Full coverage) <input type="checkbox"/> \$50 Deductible (Basic coverage) <input type="checkbox"/> No Dental Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + 2 or More Dependents		
VISION PLAN	Option: <input type="checkbox"/> Vision Coverage <input type="checkbox"/> No Vision Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + 2 or More Dependents		
EMPLOYEE LIFE INSURANCE PLAN	Option: <input type="checkbox"/> Additional 1 x Base Pay <input type="checkbox"/> Additional 2 x Base Pay <input type="checkbox"/> Additional 3 x Base Pay <input type="checkbox"/> Additional 4 x Base Pay <input type="checkbox"/> Additional 5 x Base Pay <input type="checkbox"/> No Additional Coverage	<table border="1"> <tr> <td style="background-color: black; color: white; text-align: center;">SPOUSAL LIFE INSURANCE PLAN</td> <td> <input type="checkbox"/> \$20,000 of coverage <input type="checkbox"/> \$40,000 of coverage <input type="checkbox"/> \$60,000 of coverage <input type="checkbox"/> \$80,000 of coverage <input type="checkbox"/> \$100,000 of coverage </td> </tr> </table>	SPOUSAL LIFE INSURANCE PLAN	<input type="checkbox"/> \$20,000 of coverage <input type="checkbox"/> \$40,000 of coverage <input type="checkbox"/> \$60,000 of coverage <input type="checkbox"/> \$80,000 of coverage <input type="checkbox"/> \$100,000 of coverage
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Please note: Evidence of Insurability may be required!		Please note: Evidence of Insurability may be required!		
CHILDREN'S LIFE INSURANCE PLAN	Option: <input type="checkbox"/> \$5,000 Each Child <input type="checkbox"/> \$10,000 Each Child <input type="checkbox"/> No Children Life Coverage	<table border="1"> <tr> <td style="background-color: black; color: white; text-align: center;">LONG TERM DISABILITY PLAN</td> <td> <input type="checkbox"/> Basic Coverage (40% of Base Pay) <input type="checkbox"/> Supplemental Coverage (60% of Base Pay) </td> </tr> </table>	LONG TERM DISABILITY PLAN	<input type="checkbox"/> Basic Coverage (40% of Base Pay) <input type="checkbox"/> Supplemental Coverage (60% of Base Pay)
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PERSONAL ACCIDENT INSURANCE PLAN	Option: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> No Personal Accident Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family		
FLEXIBLE SPENDING ACCOUNT	<input type="checkbox"/> ERHC - I elect to contribute \$_____ per paycheck (\$_____ annually) for the plan year to a Healthcare Reimbursement Account on a pretax basis. <input type="checkbox"/> ERDC - I elect to contribute \$_____ per paycheck (\$_____ annually) for the plan year to a Dependent Care Reimbursement Account on a pretax basis.			

Return **COMPLETED FORM** and **REQUIRED DOCUMENTS** to the Denny's Employee Benefits Department.
This form cannot be processed until all required documentation is received.

EMPLOYEE SIGNATURE: _____ DATE: _____

SALARIED BENEFITS CHANGE FORM

- To make a family or employment status change, you must complete and return this form to the following address:
Denny's, Inc.
Group Employee Department P-5-10
203 East Main Street
Spartanburg, SC 29319

You may also fax this form and documentation to: (864) 597-8888.

- This form must be received by the Benefits Department within 30 calendar days of the event for which you seek a change.
- The benefit change must be consistent with your family or employment event. For example, if you get married, you may add your new spouse to your medical coverage upon your marriage.
- You must be able to verify the family or employment change. To do this, you will need to send photocopies (DO NOT SEND ORIGINALS) of the following documents (as they apply):

<u>EVENT</u>	<u>DOCUMENTATION</u>
• Marriage	Marriage License
• Birth of Child	Proof of Birth
• Adoption of Child	Court Order
• Death	Death Certificate
• Employment Change	Letter from Employer (HIPAA - proof of other coverage)
• Divorce/Legal Separation	Court Order granting Divorce/Legal Separation

- If you are adding or dropping dependents from your medical, dental, vision, or life insurance coverage, you must also complete the Dependent / Beneficiary Change sections below.

Part C: Add / Drop Dependents

Add Dependent(s): This section must be completed if adding dependent(s)						Check Coverage(s) Requested for Dependents				
Dependent(s) LAST NAME, FIRST NAME	Relationship			Social Security Number	Date of Birth	Medical	Dental	Vision	** Life	Personal Accident
	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	(√)	(√)	(√)	(√)	(√)
				- -	- -					
				- -	- -					
				- -	- -					
				- -	- -					
				- -	- -					

Please attach a copy of the marriage license, birth certificate or court documentation for any dependent(s) listed with a different last name. ** Spousal or Children Life Insurance

Drop Dependent(s): (This section must be completed if dropping dependent(s))						
Dependent(s) LAST NAME, FIRST NAME	Relationship			Social Security Number	Date of Birth	Address
	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	
				- -	- -	
				- -	- -	
				- -	- -	

IF NOT RECEIVED WITHIN 30 DAYS OF THE EVENT, YOU MUST WAIT FOR THE NEXT ANNUAL ENROLLMENT PERIOD.

Part D: Name a New Beneficiary

Employee Life & Accidental Death & Dismemberment				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)

Personal Accident				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)

I name the above beneficiary(ies) to receive any benefits from the corresponding benefit plans that may be payable in the event of my death. I understand that this designation supersedes any prior beneficiary designation. **Forms that are not fully completed will be returned!**

Employee Signature: _____

Date: _____