

2023 Vision Election/Change Form



Salary Bargaining Unit Employee ID Number _____

BENEFITS ENROLLMENT/CHANGE REASON

NEW QUALIFYING EVENT (Check one below)

- New Hire Date (date: _____) Open Enrollment
- Mid-Year Qualifying Event (Check one below) Date of event (_____)
- Marriage Legal Separation Divorce
- Birth/Adoption/Change in Custody Loss of Other Coverage Spouse Losing Coverage
- Child No Longer Eligible Court Ordered Benefits Death of Enrolled Family Member

Other _____

You must provide documentation to support the qualifying event change (e.g., marriage license, birth certificate, divorce decree). All enrolled family members must be deemed eligible dependents under the provisions of the plan. Sibanye-Stillwater reserves the right to request proof of eligible dependent status at any time. Falsifying company records or knowingly enrolling ineligible dependents may result in disciplinary action up to and including termination of employment.

SECTION A: YOUR PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Employee is automatically covered by Stillwater Mining Company under the Vision Plan

SECTION B: DEPENDENT INFORMATION—Attach another sheet for additional dependents

Self <small>please note, employee is automatically covered by Sibanye-Stillwater under the vision plan.</small>	Check One	Name (Last, First, Mi)	Date of Birth --/--/----	Gender	
				<input type="checkbox"/> Male	<input type="checkbox"/> Female
Spouse – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Child # 1 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Child # 2 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Child # 3 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Child # 4 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP			<input type="checkbox"/> Male	<input type="checkbox"/> Female

*If you need to enrol additional dependent(s) please use an additional enrollment form & staple together *

SECTION C: EMPLOYEE AND DEPENDENT COVERAGE

Vision Plan – VSP Select Your Tier Below

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

CERTIFICATION AND SIGNATURE:

I hereby apply for coverage with the Stillwater Mining Company Vision Plan. I certify and understand the following:

- I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Application/Change of Status is a part of my and my dependents' application to be added to Stillwater Mining Company's Vision Plan. I understand that if I have misrepresented or omitted any material fact, my coverage election/change may be revoked and I will be responsible for any related premiums.
- I agree to pay and/or authorize Stillwater Mining Company to withhold from my paychecks the premiums necessary for my coverage.

Employee Signature _____ Date _____

