

__/_/___

Male

Male

Male

Male

Male

D Female

Female

Female

D Female

Employee ID Number

BENEFITS ENROLLMENT/CHANGE REASON NEW QUALIFYING EVENT (Check one below) Open Enrollment □ New Hire Date: □ Mid-Year Qualifying Event Date of Event: Marriage Legal Separation/Divorce Birth/Adoption/Change in Custody Child No Longer Eligible Loss of Coverage Spouse Losing Coverage 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 Check Date of Birth Name(Last, First, Mi) Gender Self please note, employee is

cannot have duplicate coverage unde he Sibanye-Stillwater Health plans

*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

automatically covered by Sibanye illwater under the vision plan

Spouse – please note, you

the Sibanye-Stillwater Health plans Child # 1- please note, you

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cannot have duplicate coverage unde the Sibanye-Stillwater Health plans

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Child # 2- please note, you

the Sibanye-Stillwater Health pla Child # 3 – please note, you

the Sibanye-Stillwater Health plans Child # 4 - please note, you

CERTIFICATION AND SIGNATURE:

One

ADD ADD

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ADD ADD

ADD ADD

ADD ADD

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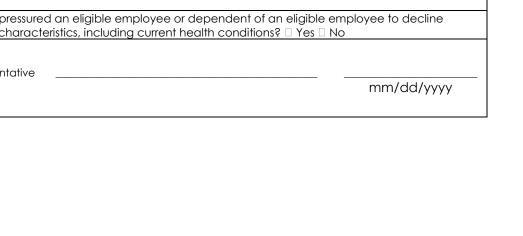
I hereby apply for coverage with the Stillwater Mining Company Vision Plan. I certify and understand the following:		
1.	I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this	
	Application/Change of Status is a part of my and my 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.	

2. Lagree to pay and/or authorize Stillwater Mining Company to withhold from my pay checks the premiums necessary for my coverage.

Employee Signature _

Date





To Be Completed by SMC HR

Date change becomes effective with the Sibanye-Stillwater Medical Plan:

Date of Hire (as an eligible employee per Plan Document):

Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? 🗆 Yes 🗆 No

Signature of Human Resources Representative

ENABLING

COMMITMENT ACCOUNTABILITY RESPECT



mm/dd/yyyy

mm/dd/yyyy

Last Name: _____ First Name: _____ Employee #: _____