2024 Vision Election/Change Form

we are one Sibanye Stillwater

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 One	Name(Last, First, Mi)	Date of Birth __/__/____	Gender	
Self please note, employee is automatically covered by Sibanye-Stillwater under the vision plan.					
Spouse – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	☐ ADD ☐ DROP			☐ Male	☐ Female
Child # 1 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	☐ ADD ☐ DROP			☐ Male	☐ Female
Child # 2 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	☐ ADD ☐ DROP			☐ Male	☐ Female
Child # 3 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	☐ ADD ☐ DROP			☐ Male	☐ Female
Child # 4 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	☐ ADD ☐ DROP			☐ Male	☐ 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:

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

Employee Signature _____ Date_____

COMMITMENT ACCOUNTABILITY RESPECT ENABLING SAFETY

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

To Be Completed by SMC HR

Date change becomes effective with the Sibanye-Stillwater Medical Plan:	_____ mm/dd/yyyy
Date of Hire (as an eligible employee per Plan Document):	_____ mm/dd/yyyy
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 _____	_____ mm/dd/yyyy