



Go Daddy Benefits Enrollment

Please mail the completed form to Go Daddy's Human Resource/Benefit Department. (14455 N. Hayden Rd. Suite 209, Scottsdale, AZ 85260)

Reason for completing this form: Open enrollment Status Change New hire Effective Date: _____

1. PERSONAL INFORMATION

Employee ID# _____

Last Name		First Name		MI	Social Security Number	
Address				City	State	ZIP
Office Location	Marital Status (Circle one) Single Married Divorced	Date of Marriage	Date of Birth	Male or Female	Home Phone	

2. SELECT YOUR MEDICAL AND DENTAL PLANS

You must complete the dependent information in Section 6 if you elect family coverage.

Medical—BCBS of AZ

Your Coverage Level

	Employee only	Employee + spouse	Employee + children	Employee + family
<input type="checkbox"/> Gold Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gold Plan - 5 Yr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Platinum Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No, I do not want to participate. I am waiving coverage.				

All Employees covered under the Go Daddy medical plan must complete a tobacco product affidavit (located in Section 7). Tobacco use for you or your dependents will increase your premiums by \$40 per pay period.

Employees with less than 5 years of service	Gold Plan
Employees with 5+ years of service	Gold Plan or Platinum Plan

You must complete the dependent information in Section 6 if you select Family coverage.

3. SELECT YOUR DENTAL PLAN

Dental—CIGNA

Your Coverage Level

Employee only	Employee + spouse	Employee + children	Employee + family
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No, I do not want to participate. I am waiving coverage.			

4. SELECT YOUR VOLUNTARY VISION PLAN

Vision—EyeMed (Plan #9721762)

Your Coverage Level

Employee only	Employee + spouse	Employee + children	Employee + family
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No, I do not want to participate. I am waiving coverage.			

5. OTHER MEDICAL COVERAGE INFORMATION

Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES NO
 Do you currently have or have had other coverage within the last 18 months? YES NO *If yes, please complete the other coverage information below.*
 To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

Health Plan Coverage Name		Carrier Phone No. (Area Code and No.)		Contract Holder Last Name		ID/Social Security Number	
Group/Policy Number	Effective Date (MM/DD/YYYY)	Cancel Date (MM/DD/YYYY)	Medicare Card No.	Part A Effective Date	Part B Effective Date		

6. LIST DEPENDENT INFORMATION

Attach a separate page for additional covered dependents.

Dependent Information

Name (Last, First, MI)	Social Security #	Covered for (check all that apply)	Student dependent 19 and older Y/N	Sex M/F	Birth Date mo/day/year
Spouse		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			

Are your spouse and/or children covered by another health/dental plan? Yes No. If yes, please list the insurance company and coverage levels.

If you decide to waive coverage, the next time you will have the option to enroll is during open enrollment. The only exception is if you have a qualified change in status, such as: getting married or divorced, having a baby or adopting a child, losing coverage under a spouse's plan, etc.



7. TOBACCO USE AFFIDAVIT

This Affidavit collects a certification from each employee covered by the medical plan regarding their tobacco use and that of their covered dependents. Beginning July 1, 2010, employees and/or their covered dependents who certify as Tobacco users will pay an additional \$40 in medical premiums per pay period. You are only eligible for the non-tobacco user medical rate after you certify that you and all of your covered dependents have been tobacco-free during the prior (6) six months.

TOBACCO USE INFORMATION

Go to <https://gdc/TobaccoAffidavit> to complete.

NOTE: Tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use. You and/or your dependent(s) may qualify for a tobacco use exemption. In order to qualify for an exemption, you will be required to provide a written statement from a physician certifying the exemption by June 25, 2010. Please contact Human Resources at HR@godaddy.com for details on how to request a tobacco exemption. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at (480) 366-3643 and we will work with you to develop another way to qualify for the reward.

8. MAKE YOUR FLEXIBLE SPENDING ACCOUNT (FSA) SELECTIONS

Flexible Spending Account (FSA)—Principal

I want to participate in our Flexible Spending Account (FSA).

Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for social security purposes, and may reduce my social security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family's status or employment as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year or applicable grace period, will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that your salary reduction election amount be reduced, regardless of the terms of your election to participate. Any amount elected in excess of a compliant election amount, must be reported as taxable income. I certify that I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

NOTE: Changes in election allowed due to a qualifying change in family status must be made no later than 30 days after the date of the qualifying change in status.

Health Care Spending Account: Annual Maximum election is \$2,000.

- I would like to contribute \$ _____ per paycheck for a total contribution of \$ _____ for the year (from July, 1 to June 30).
- No, I do not want to contribute to a health care FSA.

Dependent Care Spending Account: Annual Maximum election is \$5,000.

- I would like to contribute \$ _____ per paycheck for a total contribution of \$ _____ for the year (from July, 1 to June 30).
- No, I do not want to contribute to a dependent care FSA.

If you would like your reimbursements deposited into your bank account, complete the following information. If you are currently enrolled in the direct deposit option, you do not need to complete a new form, information will roll-over with each renewal.

Banking Information: **Checking Account Information** or **Savings Account Information**

- new set-up* change current set-up* cancel current set-up

Financial institution		
City	State	ZIP
Bank transit / ABA number	Account number	

I hereby authorize Principal Life Insurance Company to credit my FSA Reimbursement in the bank listed above. This authorization is to remain in full force and effect until I send written notice of a change or cancellation.

Signature	Dept/office name	Date
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*Your account will be prenoted for one pay period. The prenote process is done to detect any problems with your banks transit and account numbers. You will receive a regular FSA reimbursement check for the prenote pay period.



9. MAKE YOUR SUPPLEMENTAL AND DEPENDENT LIFE INSURANCE SELECTION

Go Daddy provides basic life and AD&D insurance of \$50,000 through Reliance Standard Life Insurance Company. You also have the option to purchase additional life insurance through Reliance Standard Life Insurance Company.

Voluntary Term Life

Employee coverage is available in increments of \$10,000 up to \$500,000. Proof of Good Health is required for any election amount in excess of \$400,000 if under age 70 or \$10,000 if age 70 or older.

Employee Benefit Election	<u>Amount</u>	<u>Decline</u>
	\$ _____	<input type="checkbox"/>

Dependent spouse coverage is available in increments of \$10,000 up to \$100,000 or 100% of your amount. Proof of Good Health is required for any election amount in excess of \$50,000 if under the age of 70 or \$10,000 if age 70 or older. Employee coverage is required in order to elect spouse coverage.

Spouse Benefit Election
Can not exceed 100% of the employee election

<u>Amount</u>	<u>Decline</u>	Spouse Name: _____
\$ _____	<input type="checkbox"/>	Date of Birth: _____

Dependent child(ren) coverage is available in amounts of \$5,000 or \$10,000 for those 14 days or older. The cost is the same regardless of the number of children you cover. Employee coverage is required in order to elect child(ren) coverage.

Child Benefit Election

Benefit Election—Check Box

\$5,000	\$10,000	<u>Decline</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WAIVE—Voluntary Term Life (sign only if waiving coverage)

I understand that I have been offered and have declined to purchase voluntary term life insurance. I understand that in the event I request to purchase such insurance at a later date: (1) I will be required to furnish evidence of insurability for myself and/or my dependents at my own expense; and (2) Reliance Standard Life Insurance Company will have the right to refuse my request.

 Go Daddy employee signature

 Date

10. PROVIDE YOUR BENEFICIARY INFORMATION

Note: You **must** indicate a beneficiary, even if you do not buy additional coverage.

Beneficiary Information

Because Go Daddy provides eligible employees basic life insurance, you must complete the beneficiary information below. In the event of my death, the person(s) listed below will receive all life insurance benefits I have.

Primary

Name		Relationship	
Date of Birth	Percent of benefit	Social Security Number	
Address			
City	State	ZIP	

Secondary

Name		Relationship	
Date of Birth	Percent of benefit	Social Security Number	
Address			
City	State	ZIP	

Primary

Name		Relationship	
Date of Birth	Percent of benefit	Social Security Number	
Address			
City	State	ZIP	

Secondary

Name		Relationship	
Date of Birth	Percent of benefit	Social Security Number	
Address			
City	State	ZIP	

11. REVIEW AND SIGN THE AUTHORIZATION BELOW

I authorize Go Daddy to take the necessary before-tax and after-tax deductions from my pay, based on the elections I have made. I understand that plan elections are irrevocable for the plan year, unless I have a change in family status, according to IRS regulations and approved by the Plan Administrator. I understand that falsifying information in order to obtain benefits is grounds for termination of employment.

I understand that information collected in connection with administration of the above benefit plans will be de-identified where necessary and only used or disclosed as permitted by law. Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by the carriers only as allowed by law.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud. A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the carriers.

 Go Daddy employee signature

 Date

Form No. GDOE2010