

Dresser, Inc.

Family Status Change Form

This form must be completed and returned to the Benefits Administration Group within 31 days of the date of the event. **DO NOT WAIT UNTIL YOU HAVE THE REQUIRED DOCUMENTATION--CONTACT THE BENEFITS ADMINISTRATION GROUP AND COMPLETE FORM IMMEDIATELY.** Complete both sides of the form. Be sure to make a copy for your records. Late submissions will not be considered. **Mail: Dresser Benefits Group, 15455 Dallas Parkway, Suite 1100, Addison, Texas 75001**
Fax: 1-972-361-9945; Toll Free Phone: 1-866-325-8214

SECTION A. EMPLOYEE INFORMATION

Employee Name _____ Social Security Number _____
Last First Middle Initial

Home Address _____
Street Address City State Zip

Division _____ Location _____ Daytime Phone Number _____

SECTION B. QUALIFIED STATUS CHANGE EVENTS

The following is a list of Qualified Status Change events. If your event is not listed below, please attach an explanation on a separate sheet of paper. For a detailed description of Qualified Status Changes, please refer to your Employee Benefit Handbook. If you do not have an Employee Benefit Handbook, contact your Human Resource representative.

Date of Event: _____

- You get married. Provide the following documentation: **Copy of Marriage Certificate or Employee Affidavit***
- You get divorced. Provide the following documentation: **Copy of first and last page of divorce decree with signatures and court seal or Employee Affidavit***
- Birth or Adoption of a child. Provide the following documentation: **Copy of Birth Certificate, Adoption papers or Employee Affidavit***
- Death of spouse or child. Provide the following documentation: **Copy of Death Certificate or Employee Affidavit***
- Spouse or child begins employment. Provide the following documentation: **Letter from Employer or Employee Affidavit***
- You or a dependent loses or gains benefit coverage as a result of a change in employment or employer plan. Provide the following documentation: **Letter from Former/Current Employer or Employee Affidavit***
- Child is no longer an eligible dependent. Provide the following documentation: **Employee Affidavit***

***An Employee Affidavit is a written statement explaining the reason you are requesting to make a change to your current benefit elections. The statement is not valid unless it includes a signature and date.**

Plan election made must coincide with the type of event—See Employee Benefit Handbook for allowable changes.

PLAN	THE FOLLOWING SECTIONS TO BE COMPLETED BY EMPLOYEE ONLY IF MAKING A CHANGE TO CURRENT ELECTIONS
Please call the Dresser Benefits Group toll-free at 1-866-325-8214 if you have questions about completing this form.	Requested CHANGE in Coverage Level
Medical	Plan Name: _____ Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Dental	Plan Name: _____ Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Vision (if available)	Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Optional Life – Employee (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$_____ (write in your election amount)

Optional Spouse Life (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (Write in your election amount)
Optional Child Life (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (Write in your election amount)
Optional Employee AD&D (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (Write in your election amount)
Optional Spouse AD&D (If available)	*\$.028 per \$1,000 of coverage <input type="checkbox"/> No Coverage <input type="checkbox"/> \$50,000 <input type="checkbox"/> 50% of Employee AD&D <input type="checkbox"/> 100% of Employee Amount
Optional Child AD&D (If available)	*\$.021 per \$1,000 of coverage <input type="checkbox"/> No Coverage <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000
Health Care Flexible Spending Account (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$ _____/month (\$10 min.; \$333 max)
Dependent Care Flexible Spending Account (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$ _____/month (\$10 min.; \$208 max; married separate return; \$416 max: single or married joint return)

SECTION C. DEPENDENT INFORMATION (Spouse and Children)

Please list all eligible dependents that you want to enroll for benefit coverage. See Employee Benefit Handbook for information on who qualifies as an eligible dependent. If dependent is a newborn and you do not have the SSN, send the form now and call in with the SSN as soon as possible.

Sex/ Relation*	Full Name (Last, First, M.I.)	Social Security Number	Birth Date	**Circle if Student	Circle Desired Coverage					Circle Change	
					Med	Vis	Den	OLife	AD&D	Add	Delete
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]
_____	_____	_____	_____	[S]	[M]	[V]	[D]	[L]	[Ad]	[A]	[D]

* 1 = Male Spouse; 2 = Female Spouse; 3 = Male Child; 4 = Female Child

** This refers to a full-time college student

SECTION D. EMPLOYEE AUTHORIZATION

Please enroll me in the coverages that I have indicated on this form. I have read the enrollment material provided to me and understand that eligibility and benefit coverage is governed by the official plan documents and insurance contracts, which may be modified from time to time. I also understand that eligibility for and participation in Dresser, Inc. benefits is based on the information that I have provided about myself and my eligible dependents. I certify this information is true and accurate. I also understand that any misstatement or inaccuracy may affect my eligibility for and participation in the benefit plans.

Employee Signature

Date