

<b>RETIREE INFORMATION</b>			
NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER	
HOME ADDRESS		HOME PHONE	WORK PHONE
CITY	STATE	ZIP CODE	NAME OF MEDICAL PLAN

<b>ELIGIBLE PARTICIPANTS - Include the name of the PCP or medical group that you and your dependents will use.</b>			
<b>MEMBER</b> (Last, First, Middle Initial)		<b>SPOUSE</b> (Last, First, Middle Initial)	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)
RELATIONSHIP TO EMPLOYEE		RELATIONSHIP TO EMPLOYEE	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*		PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*	

<b>CHILD</b> (Last, First, Middle Initial)		<b>CHILD</b> (Last, First, Middle Initial)	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)
RELATIONSHIP TO EMPLOYEE		RELATIONSHIP TO EMPLOYEE	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*		PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*	

<b>CHILD</b> (Last, First, Middle Initial)		<b>CHILD</b> (Last, First, Middle Initial)	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY (mm/dd/yyyy)
RELATIONSHIP TO EMPLOYEE		RELATIONSHIP TO EMPLOYEE	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*		PRIMARY CARE PHYSICIAN OR MEDICAL GROUP*	

Eligible children are covered to age 19. Coverage may continue beyond age 19 for full-time students up to age 25. Attach a separate sheet of paper to this form if you need more space.  
\*Refer to the HMO/EPO provider directory for the plan option you selected.

<b>SIGNATURE SECTION</b>	
<p>I certify that the above information is correct, and I authorize Northrop Grumman to take pretax payroll deductions, when necessary, to pay for the benefit elections indicated on this form. I understand that misrepresentation of the above information or nonpayment of the copayment, if any, may result in cancellation of membership. I also understand and agree to the following:</p> <ol style="list-style-type: none"> <li>I agree to abide by the provisions of the plan(s) I selected.</li> <li>Any differences between myself and/or my dependents and the health plan(s) are subject to binding arbitration.</li> <li>I will notify Northrop Grumman of any change in my dependents's status within 31 days of the change.</li> <li>My medical records and those of my dependents may be disclosed to the health plan for purposes of quality assurance, regulatory surveys, processing of claims, and financial audit, or purposes reasonably related to the performance of this agreement.</li> <li>I will personally bear any costs of health care or drugs that I or my dependents incur that are not covered or authorized by this plan.</li> </ol>	
SIGNATURE	DATE
<p><b>Mail to: Northrop Grumman Benefits Center, P.O. Box 4872, Chesapeake, VA 23327-4872</b></p>	