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**Your 2014 Benefit Elections -** Submit your completed form by November 8, 2013 to[**powerofyoubenefits@exelisinc.com**](mailto:powerofyoubenefits@exelisinc.com)**. If you do not wish to make an HSA or FSA election and you have no dependent or plan changes, you do not need to complete this form.** Your current medical, dental and vision plan elections will be copied automatically for the 1/1/2014 benefit year.

**Section I: YOU**

|  |  |  |
| --- | --- | --- |
| First Name:Mark | Last Name: Hazel | Last 4 of Social Security #:0131 |
| Work Email:mark.hazel@exelisinc.com | | Daytime Phone:585-281-3665 |

## Section II: People YOU Want to Cover Under Benefit Plans

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name** | Birth Date | **Gender** | Relationship to Employee\* | Social Security Number | **Coverage Election** |
|  |  |  |  |  | Med  Dent  Vis |
|  |  |  |  |  | Med  Dent  Vis |
|  |  |  |  |  | Med  Dent  Vis |
|  |  |  |  |  | Med  Dent  Vis |
|  |  |  |  |  | Med  Dent  Vis |
| \* If your dependents have not been previously covered under an Exelis Medical plan, you must provide proof of dependent eligibility. A marriage certificate or affidavit of Domestic Partnership must be provided to cover any Wife, Husband or Same Sex Domestic Partner. A birth certificate must be provided for each dependent child you are covering showing either your name as a parent or the name of your spouse/domestic partner as a parent. A copy of the court order is required for adoption and legal custody of a dependent child. | | | | | |

**Section III: YOUR Benefit Elections**

**Per paycheck pre-tax contribution rates are shown on the 2014 Premiums page on** [**www.exelispowerofyou.com**](http://www.exelispowerofyou.com)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MEDICAL PLAN** | **Waive** | **Employee Only** | **Employee + Spouse/DP** | **Employee + Child(ren)** | **Family** |
| Exelis Health Savings Plan (EHSP) |  |  |  |  |  |
| Exelis Health Plan (EHP) |  |  |  |  |  |
| I choose to Waive Medical coverage for 2014 |  |  |  |  |  |
| **DENTAL PLAN** | **Waive** | **Employee Only** | **Employee + Spouse/DP** | **Employee + Child(ren)** | **Family** |
| Exelis National MetLife Dental PPO Plan |  |  |  |  |  |
| I choose to Waive Dental coverage for 2014 |  |  |  |  |  |
| **VISION PLAN** | **Waive** | **Employee Only** | **Employee + Spouse/DP** | **Employee + Child(ren)** | **Family** |
| Exelis National EyeMed Vision Plan |  |  |  |  |  |
| I choose to Waive Vision coverage for 2014 |  |  |  |  |  |
| **FSA/HSA PLANS** | **Waive** | **Contribute** | | | |
| **Healthcare Flexible Spending Account (HFSA)** (not available with EHSP) |  | I elect an annual contribution of: $      **(min$100/ max $2,500)** | | | |
| **Dependent Day Care Flexible Spending Account (DFSA)** |  | I elect an annual contribution of: $       **(min$100/max $5,000)** | | | |
| **Health Savings Account (HSA) only allowed with EHSP You must also complete the HSA bank account application form on mycigna.com** |  | I elect an annual contribution of: $      **(max $2,900single/$5,750 family)** | | | |
| **Health Savings Account Catch-up**  **only allowed with EHSP** |  | I am at least 55 years old this year and  I elect an annual contribution of: $      **(max $1,000)** | | | |

**I authorize the Company to deduct from my salary the required premium contributions for the coverage(s) elected above. I acknowledge reviewing and understanding plan provisions and eligibility rules for these benefit plans. I understand that Exelis retains the right to audit enrollment and eligibility and that falsely certifying dependency status is a violation of Company policy. I verify that the information provided on this form is accurate and complete. Further, I understand that any change in these coverage elections can only be made as outlined in the Summary Plan Description.**

Mark T Hazel 11/05/2013

Employee Signature (type name for electronic signature) Date

Exelis logo