



Enrolled Dependents Verification Form

Section A Introduction	Each employee in receipt of this form is required to respond and verify that each dependent meets the plan definitions as detailed on the back side of this form under "Definition of Eligible Dependent". You verify coverage by marking either columns A or B below for each listed dependent. If the dependent does not meet the criteria described on the back side of this form under "Definition of Eligible Dependent", please mark column A. The dependent will be removed from your coverage on 9/30/2009 and will not be eligible for COBRA unless you notify Gina Zylla of your dependent's qualifying event within 60 days after the event occurs.				
Section B Instructions	<u>Rodney L Larson</u> <u>Mailstop: 217</u> <u>Action Required by 8/21/2009</u>			Instructions for Sections C & D: 1. Place a check mark in column A if your dependent should be removed from your <u>Employee + 1</u> medical and <u>Employee + Spouse</u> dental coverage. 2. Place a check mark in column B if your dependent should be kept on your <u>Employee + 1</u> medical and <u>Employee + Spouse</u> dental coverage.	
Section C Your current covered dependents under the MTS Medical Plan	Dependent's Name	Relationship	Birth Date	A Remove from MTS Medical Plan	B Keep on MTS Medical Plan
	<u>Larson, Jovelisa</u>	<u>Spouse</u>	<u>2/24/1982</u>		
Section D Your current covered dependents under the MTS Dental Plan	Dependent's Name	Relationship	Birth Date	A Remove from MTS Dental Plan	B Keep on MTS Dental Plan
	<u>Larson, Jovelisa</u>	<u>Spouse</u>	<u>2/24/1982</u>		
Section E Employee Authorization	This form must be signed by you and returned to contact noted below no later than Friday, August 21, 2009. Failure to respond will result in the termination of coverage for all the dependents listed above and your coverage will be changed to employee only effective October 1, 2009.				
	I attest that the above dependents for whom I indicated to keep on my medical and dental coverage meet the eligibility requirements under the MTS Medical and MTS Dental Plan as described on the back side of this form under "Definition of Eligible Dependent". I understand that I may be randomly audited and required to submit proof of dependent status. I understand that if it is subsequently determined that my dependent(s) does not meet the plan eligibility rules (other than those dependents I voluntarily remove), I will be considered to have falsified records which will result in penalties that may include repayment of premium, repayment of claims, and possible termination of employment.				
	<u>Employee Signature</u>			<u>Date</u>	

Mail or Fax to: MTS Interoffice Mail to Gina Zylla, MS#125, or fax to Gina Zylla at 952-974-8601,
or send via first class mail to: MTS Systems Corporation, Attention: Gina Zylla, MS#125, 14000 Technology Drive, Eden Prairie, MN 55344
OFFICE USE ONLY* Employee Name & #: Rodney L Larson, #1938

Date Received		Date Sent Receipt or Cancellation Notice	
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