6099511225

Clear Channel Communications, Inc.
Employee Benefits Enrollment Form

Enrollment Form: Plan Year 2007
Please be sure to fill out the form below in ink, read and sign.

1. FOR OFFICE USE

CCC Date of Hire: __ / __ / ____
Eff. Date: __ / __ / ____
Basic Eligible Salary: _____ Loc. #: ____

Please write your responses in PRINTED CAPITAL LETTERS without touching the sides like the Example Shown Below:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8 9

2. EMPLOYEE INFORMATION

Listed below is your information in our employee database. **PLEASE ENTER ONLY CHANGES YOU HAVE IN YOUR CURRENT INFORMATION BELOW.** For example, if you had a change in your address, enter your new address ONLY in the boxes below. Also, if information is missing, like date of hire or marital status, please fill in. Thank you for helping us ensure we have the latest information for your Benefits Enrollment.

ROBERT **M**
ANDERSON
1234 N. MAIN STREET **APT G**
SAN ANTONIO **TX** **20345**

Employee SSN: **123-45-6789**
Date of Birth: **11/27/67**
Original Date of Hire: **06/12/92**
Phone Number: **203 782-1324**
Sex: ○ M ○ F

STOP **Please remember to only enter new, changed, or missing information in the boxes below!**

First Name: _____ MI: ____ Employee Social Security Number: ___ - __ - ____
Last Name: _____ Date of Birth: __ / __ / __ Original Date of Hire: __ / __ / __
Address Line 1: _____ Address Line 2: _____
City: _____ State: ____ Zip Code: _____ - ____ Sex: ○ M ○ F
Home Phone Number: ___ - ___ - ____ Work Phone Number: ___ - ___ - ____
Marital Status: ○ Single ○ Married ○ Legally Separated ○ Widowed ○ Divorced

3. MARK THE COVERAGES YOU ARE APPLYING FOR

Please mark the coverages you are electing. Pre-tax payroll deductions will be made for the medical and dental plans and flexible reimbursement accounts. All other deductions will be made on a post-tax basis. You will be restricted from amending an election until the next annual enrollment period. Refer to the Enrollment Guide for more information. If you do not mark an election, it will default to decline. Use the Benefits Cost Worksheet found in your Enrollment Guide to estimate your costs.

MEDICAL PLAN EMPLOYEE ONLY
(fill-in one) If the above is correct, fill-in No Change below

No Change
Employee Only
Employee & Spouse
Employee & Child(ren)
Employee, Spouse & Child(ren)
I decline all Medical Plan coverage

DENTAL PLAN
(fill-in one) If the above is correct, fill-in No Change below

No Change
Employee Only
Employee & Spouse
Employee & Child(ren)
Employee, Spouse & Child(ren)
I decline all Dental Plan coverage

4. FLEXIBLE REIMBURSEMENT ACCOUNTS

Health Care Account $ ____ . __ per year (Minimum $120; Maximum $3,000) Decline

Dependent Day Care Account (not related to medical) $ ____ . __ per year (Minimum $120; Maximum $5,000) Decline

5. SHORT TERM DISABILITY (STD)

Please read the back of this page for information related to the Short Term Disability Plan and mark either Accept or Decline below. You must have worked full-time for Clear Channel for at least one year.

Accept **Decline**

6. PLEASE LIST ALL COVERED DEPENDENTS

STOP I understand all eligible family members must be listed below in order to be covered. If the covered dependent information listed below is complete and accurate, and you want these dependents covered, then no additional action is required. Further, I understand if my eligible dependents are covered by another health plan, I must complete the "OTHER MEDICAL COVERAGE" section below. List additional children on a separate sheet and staple to this form.

○ Add ○ Change ○ Cancel
SPOUSE FIRST NAME _____ SPOUSE LAST NAME _____
SPOUSE DATE OF BIRTH __ / __ / __ SPOUSE SSN ___ - __ - ____
SEX/RELATIONSHIP ○ Husband ○ Wife
* OTHER MEDICAL COVERAGE ○ Yes ○ No
*If Other Medical Coverage, Carrier Name

○ Add ○ Change ○ Cancel
CHILD FIRST NAME _____ CHILD LAST NAME _____
CHILD DATE OF BIRTH __ / __ / __ CHILD SSN ___ - __ - ____
SEX/ RELATIONSHIP ○ Son ○ Daughter | OTHER MEDICAL COVERAGE ○ Yes ○ No | FULL TIME STUDENT ○ Yes ○ No

○ Add ○ Change ○ Cancel
CHILD FIRST NAME _____ CHILD LAST NAME _____
CHILD DATE OF BIRTH __ / __ / __ CHILD SSN ___ - __ - ____
SEX/ RELATIONSHIP ○ Son ○ Daughter | OTHER MEDICAL COVERAGE ○ Yes ○ No | FULL TIME STUDENT ○ Yes ○ No

○ Add ○ Change ○ Cancel
CHILD FIRST NAME _____ CHILD LAST NAME _____
CHILD DATE OF BIRTH __ / __ / __ CHILD SSN ___ - __ - ____
SEX/ RELATIONSHIP ○ Son ○ Daughter | OTHER MEDICAL COVERAGE ○ Yes ○ No | FULL TIME STUDENT ○ Yes ○ No

○ Add ○ Change ○ Cancel
CHILD FIRST NAME _____ CHILD LAST NAME _____
CHILD DATE OF BIRTH __ / __ / __ CHILD SSN ___ - __ - ____
SEX/ RELATIONSHIP ○ Son ○ Daughter | OTHER MEDICAL COVERAGE ○ Yes ○ No | FULL TIME STUDENT ○ Yes ○ No

Employee's signature for all elections made: X _____
Date Signed: X _____