



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:

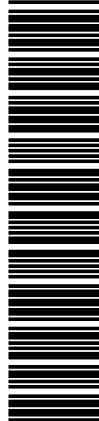
Alphabet and number grid for printing responses

2. EMPLOYEE INFORMATION

Listed below is your information in our employee database. PLEASE ENTER ONLY CHANGES YOU HAVE IN YOUR CURRENT INFORMATION BELOW.

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



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

Form for entering personal information: First Name, Last Name, Address Line 1, Address Line 2, City, State, Zip Code, Home Phone Number, Work Phone Number, Date of Birth, Original Date of Hire, Employee Social Security Number, Marital Status, Sex.

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.

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 \$ [] 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

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.

Form for listing spouse: SPOUSE FIRST NAME, SPOUSE LAST NAME, SPOUSE DATE OF BIRTH, SPOUSE SSN, SEX/RELATIONSHIP, OTHER MEDICAL COVERAGE, *If Other Medical Coverage, Carrier Name

Form for listing child 1: CHILD FIRST NAME, CHILD LAST NAME, CHILD DATE OF BIRTH, CHILD SSN, SEX/RELATIONSHIP, OTHER MEDICAL COVERAGE, FULL TIME STUDENT

Form for listing child 2: CHILD FIRST NAME, CHILD LAST NAME, CHILD DATE OF BIRTH, CHILD SSN, SEX/RELATIONSHIP, OTHER MEDICAL COVERAGE, FULL TIME STUDENT

Form for listing child 3: CHILD FIRST NAME, CHILD LAST NAME, CHILD DATE OF BIRTH, CHILD SSN, SEX/RELATIONSHIP, OTHER MEDICAL COVERAGE, FULL TIME STUDENT

Form for listing child 4: CHILD FIRST NAME, CHILD LAST NAME, CHILD DATE OF BIRTH, CHILD SSN, SEX/RELATIONSHIP, OTHER MEDICAL COVERAGE, FULL TIME STUDENT

Employee's signature for all elections made

Date Signed

X

X