Mercer Administration, A Service of Seabury & Smith, Inc. co. # ____________ ee. # ________

## A. Application Type

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee (indicate event & date below) ☐ Change (indicate event & date below) ☐ Open Enrollment

Event Requiring Contract Change: ☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Other ________ Event Date ________

| SSN | Name (Last) | (First) | (MI) |
|---|---|---|---|
| Birth Date | Address (Street) | | (Apt/Ste #) |

| Gender ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Common Law | (City) | (State) | (Zip) | (Phone Number) |
|---|---|---|---|---|---|

Medicare Enrolled? ☐ Yes ☐ No Soc. Sec. Disabled? ☐ Yes ☐ No Medicare ID (HIC) No. ☐ Part A ☐ Part B ☐ Part D Eff. Date:

## B. Coverage Election – Please indicate the coverage you are choosing

| | | | | |
|---|---|---|---|---|
| Medical (if applicable): | ☐ Self | ☐ Spouse | ☐ Child(ren) | Plan Type________ |
| Dental (if applicable): | ☐ Self | ☐ Spouse | ☐ Child(ren) | Plan Type________ |
| Vision (if applicable): | ☐ Self | ☐ Spouse | ☐ Child(ren) | Plan Type________ |
| HSA (if applicable): | ☐ Self | ☐ Spouse | ☐ Child(ren) | Plan Type________ |

☐ Life ☐ AD & D ☐ STD ☐ LTD

## C. Employer – Please complete shaded section for applicant

| Company Name | | Applicant Occupation | |
|---|---|---|---|
| Company Location | Class | Employer Signature | Date |

| Hire Date | Eff. Date |
|---|---|

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA Salary $ ☐ Monthly ☐ Annually

Please indicate plan if multiple plans are available: ☐ Health ________ ☐ Dental ________ ☐ Vision________

| ☐ Employee Life | ☐ Employee AD&D | ☐ Employee Opt. Life | ☐ Dependent Life | ☐ Spouse Opt. Life | ☐ Employee STD | ☐ Employee LTD |
|---|---|---|---|---|---|---|
| $ | $ | $ | $ | $ | $ | $ |

## D. Beneficiary Information

| | Birth Date | SSN | Relationship | % |
|---|---|---|---|---|
| Primary Beneficiary | | | | |
| Contingent Beneficiary | | | | |

## E. Dependents Enrolled

| (First, MI, Last) | Birth Date | Social Security Number | Does dependent reside at home? | Gender | Full-Time Student? | Soc. Sec. Disabled? | Medicare Enrolled? |
|---|---|---|---|---|---|---|---|
| Spouse | | | | ☐ M ☐ F | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No | ☐ M ☐ F | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No | ☐ M ☐ F | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No | ☐ M ☐ F | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No | ☐ M ☐ F | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

## F. Other Coverage Information

If you, your spouse or anyone named on this application will keep other hospital and/or medical coverage in addition to this coverage, please complete the following:

| Name (First, MI, Last) | Employer (if applicable) | | |
|---|---|---|---|
| Insurance Company/ HMO Name and Address | Policy No. | Contract Type: ☐ Single -Medical ☐ Family -Medical ☐ 2 person-Medical | Eff. Date: |

## G. Employee Waiver of Coverage

I, the undersigned, hereby certify that I have been given an opportunity to enroll in the group plan sponsored by my employer. After careful consideration, I have elected not to participate in the following coverage(s). I further understand that, should I decide to participate at a future date, I may have to furnish satisfactory evidence of insurability for myself and, if applicable, any eligible dependents. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- ☐ Employee Health
- ☐ Employee Dental
- ☐ Employee Vision
- ☐ Employee Life
- ☐ Employee AD&D
- ☐ Employee Weekly Indemnity (STD)
- ☐ Employee Long Term Disability (LTD)
- ☐ Employee Optional Life
- ☐ Spouse Optional Life
- ☐ Dependent Health
- ☐ Dependent Dental
- ☐ Dependent Vision
- ☐ Dependent Life
- ☐ Other ________

Employee Signature________________

Date________________

Witness Signature________________

Date________________

## H. Employee Signature (Required for all available lines of coverage)

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the coverage elected on this form. I hereby represent that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my annual earnings and I further represent that I am not presently disabled and I am performing all the duties of my occupation. (This statement applies to any disability coverage).

Signature________________ Date________________

OFFICE USE ONLY

UPDATE STAMP HERE