

**Mercer-Auglaize Employee Benefit Trust  
Health Insurance Enrollment/Change Form**

**For Office Use Only**

|  |                                 |                |
|--|---------------------------------|----------------|
| <b>District:</b>                         | Certified by:                   | Phone/Ext:     |
| <input type="checkbox"/> New Enrollment  | <input type="checkbox"/> Change |                |
| <input type="checkbox"/> Open Enrollment | Reason for Change:              | Effective Date |

**Employee must complete all sections below**

**Employee Information**

|                        |                                   |
|------------------------|-----------------------------------|
| Name (Last, First, MI) | Hire Date                         |
| Street Address         | Date of Birth                     |
| City/State/Zip         | Social Security No.               |
| Home Phone ( )         | Previous last name if applicable: |

**Marital Status**

Check appropriate box(es) and furnish date(s). If ever divorced and are enrolling dependents from that marriage, please see your local HR contact person.

|  |  |       |                                    |       |
|--|--|-------|------------------------------------|-------|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Legally Separated | Date: | <input type="checkbox"/> Widowed   | Date: |
| <input type="checkbox"/> Married       | <input type="checkbox"/> Divorced          | Date: | <input type="checkbox"/> Remarried | Date: |

**Plan Choices** Indicate your choice in each of the areas below.

|                                   |   |                                    |                                     |                                   |  |                                    |                                     |
|-----------------------------------|---|------------------------------------|-------------------------------------|-----------------------------------|--|------------------------------------|-------------------------------------|
| <b>Medical</b>                    |   |                                    |                                     | <b>Dental</b>                     |  |                                    |                                     |
| Choose One Coverage Type<br>→ → → | <input type="checkbox"/> First Dollar                         | Choose One Coverage Level<br>→ → → | <input type="checkbox"/> Family     | Choose One Coverage Type<br>→ → → | <input type="checkbox"/> Traditional               | Choose One Coverage Level<br>→ → → | <input type="checkbox"/> Family     |
|                                   | <input type="checkbox"/> Comp A                               |                                    | <input type="checkbox"/> Individual |                                   | <input type="checkbox"/> PPO                       |                                    | <input type="checkbox"/> Individual |
|                                   | <input type="checkbox"/> Comp B                               |                                    |                                     |                                   |  |                                    |                                     |
|                                   | <input type="checkbox"/> PPO                                  |                                    |                                     |                                   |  |                                    |                                     |
|                                   | <input type="checkbox"/> I decline Medical Coverage           |                                    |                                     |                                   | <input type="checkbox"/> I decline Dental Coverage |                                    |                                     |
| <b>Prescription Drug</b>          |   |                                    |                                     |                                   |  |                                    |                                     |
| Choose One Coverage Type<br>→ → → | <input type="checkbox"/> I want Prescription Drug Coverage    | Choose One Coverage Level<br>→ → → | <input type="checkbox"/> Family     |                                   |  |                                    |                                     |
|                                   |   |                                    | <input type="checkbox"/> Individual |                                   |  |                                    |                                     |
|                                   | <input type="checkbox"/> I decline Prescription Drug Coverage |                                    |                                     |                                   |  |                                    |                                     |

**Dependent Information (Complete for family plans only)** Please use an additional form if you need more space.

|   |  | Name (Last, First, MI) | Relationship  | Coverage (Check)  | Date of Birth | Gender | Social Security Number |
|---|--|------------------------|---------------|---|---------------|--------|------------------------|
| 1 | <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop |                        | <b>Spouse</b> | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Prescription |               |        |                        |
| 2 | <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop |                        |               | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Prescription |               |        |                        |
| 3 | <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop |                        |               | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Prescription |               |        |                        |
| 4 | <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop |                        |               | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Prescription |               |        |                        |
| 5 | <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop |                        |               | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Prescription |               |        |                        |

**Other Health Insurance Information**

Do you or any of your family members have other Group Health and/or Dental Insurance (Including medicare)?  Yes  No

If yes, name of insured person: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name and Address of Employer: \_\_\_\_\_

|              |                               |               |                    |
|--------------|-------------------------------|---------------|--------------------|
|              | Insurance Company or Medicare | Policy Number | Dependents Covered |
| Medical Plan |                               |               |                    |
| Dental Plan  |                               |               |                    |

**Certification and Signatures**

I hereby consent and authorize any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any information regarding the medical records concerning myself or a member of my family to CoreSource, Inc., for the purpose of supervising and monitoring the health plan(s). This consent shall be valid until revoked, in writing, by me. Further, I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Attach HIPAA Certificates of Coverage (if applicable) for employee and/or dependents that you have received for previous coverage from other medical plans

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_