

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

For Office Use Only							
District:		Certified by:		Phone/Ext:			
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change						
<input type="checkbox"/> Open Enrollment	Reason for Change:		Effective Date				
<b>Employee must complete all sections below</b>							
<b>Employee Information</b>							
Name (Last, First, MI)			Hire Date				
Street Address			Date of Birth				
City/State/Zip			Social Security No.				
Home Phone ( )		Previous last name if applicable:					
<b>Marital Status</b>							
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	Date:	<input type="checkbox"/> Divorced	Date:	<input type="checkbox"/> Remarried	Date:		
<b>Plan Choices</b> Indicate your choice in each of the areas below.							
<b>Medical</b>				<b>Dental</b>			
Choose One Coverage Type → → →	<input type="checkbox"/> First Dollar	Choose One Coverage Level → → →		Choose One Coverage Type → → →	<input type="checkbox"/> Traditional	Choose One Coverage Level → → →	
	<input type="checkbox"/> Comp A				<input type="checkbox"/> Family		
	<input type="checkbox"/> Comp B				<input type="checkbox"/> Individual		
	<input type="checkbox"/> Alt PPO						
	<input type="checkbox"/> Trad PPO						
<input type="checkbox"/> I decline Medical Coverage				<input type="checkbox"/> I decline Dental Coverage			
<b>Prescription Drug</b>							
Choose One Coverage Type → → →	<input type="checkbox"/> I want Prescription Drug Coverage	Choose One Coverage Level → → →			<input type="checkbox"/> Family		
					<input type="checkbox"/> Individual		
	<input type="checkbox"/> I decline Prescription Drug Coverage						
<b>Dependent Information (Complete for family plans only)</b> 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 <input type="checkbox"/> Add <input type="checkbox"/> Drop	<b>Spouse</b>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription				
2	<input type="checkbox"/> Continue <input type="checkbox"/> Add <input type="checkbox"/> Drop		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription				
3	<input type="checkbox"/> Continue <input type="checkbox"/> Add <input type="checkbox"/> Drop		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription				
4	<input type="checkbox"/> Continue <input type="checkbox"/> Add <input type="checkbox"/> Drop		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription				
5	<input type="checkbox"/> Continue <input type="checkbox"/> Add <input type="checkbox"/> Drop		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription				
<b>Other Health Insurance Information</b>							
Do you or any of your family members have other Group Health and/or Dental Insurance (including Medicare)? <input type="checkbox"/> Yes <input type="checkbox"/> 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							
<b>Certification and Signatures</b>							
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							
<b>Signature of Employee:</b>				<b>Date:</b>			