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_____

☐ 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	Gender	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ 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

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. Prior Coverage Information

– Did you have health insurance in the last 63 days? If yes, please complete the following section:

Name of Covered Person

Employer (if applicable)

Insurance Company/
HMO Name and Address

Policy No.	Contract Type: ☐ Single -Medical ☐ Family -Medical ☐ 2 person-Medical	Eff. Date: End Date:

H. 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_____

I. 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_____

Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am applying for coverage as indicated on the reverse side of this application which is underwritten by Wellmark, Inc., doing business as Blue Cross and Blue Shield of Iowa providing the specified health care coverage, and Fort Dearborn Life Insurance Company or Medical Life Insurance Company providing the life insurance (collectively, the "Insurers"). I authorize my employer as my agent, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until I or my employer notifies the Insurers to the contrary. I further understand that coverage applied for will not start until after this application and the appropriate premium payment amount are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

I certify that, after this application was completed, I carefully and fully read it and that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication has been knowingly withheld. I understand that the Insurers will rely on the completeness and truthfulness given in the statements made in this application, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, each Insurer will be entitled to declare coverage provided under this application void and to refuse allowance of benefits to any person there under. I authorize any health care provider to release medical records to the Insurers when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I further agree upon request to furnish the Insurers all information required to administer the requested coverage.