Enrollment and Change Form

Please print or type clearly in blue or black ink.

EMPLOYER SECTION Please complete for employee

Agency Name _____Agency State _____Co #_____
(from the bills of current members)

CHECK ONE: ☐ New Enrollment ☐ Addition ☐ Change
☐ Voluntary Cancellation ☐ Non Voluntary Cancellation ☐ Other _____

Date of Hire _____ Effective Date of Change _____

Type of Change _____ Reason for Change _____

EMPLOYEE INFORMATION

_____ _____
Name (Last) (First) (MI) Social Security Number

_____ _____ _____ _____
Address City State ZIP

Gender Status
☐ Male ☐ Single Date of Birth _____ Occupation _____
☐ Female ☐ Married

MEDICAL PLAN (check one)
☐ Employee ☐ Employee + Spouse
☐ Family ☐ EE/+ Child(ren)
☐ Coverage Waived

☐ Not applicable *(Benefit not offered by authority)*

Circle Plan Type - (Premier PPO, Value PPO, Value PPO w/Premier RX, Out of Area, Premier Partial PPO)

LIFE AD&D INSURANCE
☐ Life Insurance/AD&D Coverage - $10,000
☐ Life Insurance/AD&D Coverage - $50,000
☐ Life Insurance/AD&D Coverage –☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ Other: Per $1,000 = _____
☐ Not applicable (Benefit not offered by authority)

☐ **Optional Dependent Life**: $2,000 for Spouse and $1,000 per child
☐ Not applicable (Benefit not offered by authority)

Beneficiary/Beneficiaries (Last, First, MI)	Percentage of Benefit	Relationship
_____	_____	_____
_____	_____	_____

DENTAL PLAN (check one)
☐ Employee ☐ Employee + Spouse
☐ Family ☐ EE/+ Child(ren) ☐ Coverage Waived

☐ Not applicable *(Benefit not offered by authority)*
Benefit through United Healthcare
(**www.welcometouhc.com/openaccess**) 888-679-8925

VISION PLAN (check one) - **VSP**	☐ Not applicable *(Benefit not offered by authority)*
☐ Employee ☐ Employee + Spouse ☐ Family ☐ Employee + Child(ren) ☐ Coverage Waived	Benefit through Vision Service Plan (**www.vsp.com**) 800-877-7195

VISION PLAN (check one) - **UHC**	☐ Not applicable *(Benefit not offered by authority)*
☐ Employee ☐ Employee + Spouse ☐ Family ☐ Employee + Child(ren) ☐ Coverage Waived	Benefit through United Healthcare (**www.myuhcvision.com**) 800-638-3120

LONG TERM DISABILITY	☐ Not applicable *(Benefit not offered by authority)*
☐ Long Term Disability ☐ Coverage Waived	Monthly Salary $_____ Occupation_____

DEPENDENT INFORMATION

Please list all eligible family members to be enrolled in medical, dental and/or vision coverage. Add separate sheet if necessary.

Dependent Full Name	Sex	Date of Birth	Social Security #	Relationship	Medical	Dental	Vision

AUTHORIZATION

** I accept the coverage provided by **Housing Benefits Plan** and authorize deductions from earnings of the required contributions, if any, towards the cost of my coverage. This authorization applies only if employee contributions are required.

** Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

** I understand and acknowledge that **Housing Benefits Plan** is a tax qualified voluntary employees' beneficiary association sponsored by SERC-NAHRO & SWRC-NAHRO and not by my employer. I further acknowledge and agree that **Housing Benefits Plan** is subject to the provisions of the Internal Revenue Code and ERISA.

** I hereby certify that the foregoing information is true and correct to the best of my knowledge and accept the provisions above.

** I have read and understand the eligibility rules and represent and warrant the people I have enrolled are eligible.

Employee Signature _____ Date _____

For individuals making changes to their coverage or being added to the Housing Authority's plan, please scan/email or fax this completed form to your current Mercer representative which is listed in the top right hand corner of your billing invoice.

For housing authorities initially enrolling with HBP, please scan/email or fax all completed forms to Susan at sstrange@oeccwildblue.com or 318-371-1224.