Enrollment and Change Form

Please print or type clearly in blue or black ink.

EMPLOYER SECTION Please complete for employee

Agency Name _____ Agency State _____ Billing Acct #_____
(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 or Write Plan Name - (Value PPO, Value PPO w/Premier RX, Premier PPO, Premier Plus PPO, Out of Area)

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	
☐ Long Term Disability ☐ Coverage Waived ☐ Not applicable (Benefit not offered by authority)	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 or terminated from the Housing Authority's plan, please post this completed form to your Housing Authority's Sharepoint site with Mercer.