Enrollment/Change Form

□ New Enrollment □ Change □ Termination Effective Date: __ / __ / ____ Reason for Change: _____

Employer: **MERCER-AUGLAIZE**	District: **St. Marys City Schools**
Employee Name: *Last, First, Middle:*	
Address: *Number & Street:*	Apt. #:
City: State: Zip: Phone:	

Gender	Hire/Rehire Date:	Date of Birth:	Social Security #:	Current Marital Status	If Status Change
☐ Male ☐ Female				☐single ☐widowed ☐married ☐divorced	Date of Change: / /

Social Security numbers are required for all participants (employee and dependents) of the plan. This number will not appear on your ID card.
CMS Reporting requires the plan to report this information to Medicare administration.

BENEFIT SELECTION

Benefit	Plan	Coverage
Medical	**□ PPO ($0 Deductible) □ Alt PPO ($500/$1500 Deductible)**	**□ Single / □ Family**
Rx	**□ Express Scripts**	**□ Single / □ Family**
Dental	**□ Dentemax Plan □ Superior Plan**	**□ Single / □ Family**
Vision	**□ VSP**	**□ Single / □ Family**

DEPENDENTS TO BE ENROLLED

(Please fill in all boxes that apply)

Last Name, First Name, Mid Int	Relationship	Sex	Birth Date	Social Security #	Benefits
Spouse:		☐M ☐F			☐ Med ☐ Rx ☐ Den ☐ Vis
Child:		☐M ☐F			☐ Med ☐ Rx ☐ Den ☐ Vis
Child:		☐M ☐F			☐ Med ☐ Rx ☐ Den ☐ Vis
Child:		☐M ☐F			☐ Med ☐ Rx ☐ Den ☐ Vis
Child:		☐M ☐F			☐ Med ☐ Rx ☐ Den ☐ Vis

PRIOR COVERAGE

**Answer the following question below, only if you are a new hire.
Did you have coverage prior to enrolling with MERCER AUGLAIZE? ☐ Yes ☐ No
If YES: Please submit a Certificate of Creditable Coverage to Mutual Health Services, PO Box 4138, Akron, OH 44321

OTHER INSURANCE

☐ **No members of my family are covered by any other plan of insurance.**
☐ **The following members are covered by other insurance plans as noted below.**

	Employee:	Spouse:	Child: _____	Child: _____
Policy Holders Name:				
Insurance Company:				
Coverage Tier:	☐ Single ☐ Family	☐ Single ☐ Family	☐ Single ☐ Family	☐ Single ☐ Family
Coverage Type:	☐ Med ☐ Den ☐ Rx	☐ Med ☐ Den ☐ Rx	☐ Med ☐ Den ☐ Rx	☐ Med ☐ Den ☐ Rx

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Mutual Health Services. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature of Employee _____ **Date Signed** _____

COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE ALL OR PART OF THE COVERAGE OFFERED

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: □ Medical □ RX □ Dental Reason for Waiving _____
Waiver for: □ Employee □ Spouse □ Child(ren)

Signature of Employee _____ Date Signed _____

Please return all completed forms to the school Treasurer