



2022 HALLMARK ENROLLMENT FORM

Please complete this 2-sided enrollment form.

Retiree/Surviving Spouse Information				084743010101
Last Name, First Name, Middle Initial		Gender	Birth Date (MM/DD/YYYY)	
Permanent residence street address (PO Box is not allowed):		City	State	Zip
Mailing Address (only if different from your permanent address):		City	State	Zip
Home Phone	Employee ID	Date of Retire		
Social Security Number (CIGNA/Mercer use only)				

Spouse Information	
Last Name, First Name, Middle Initial	
Birth Date (MM/DD/YYYY)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Social Security Number (CIGNA/Mercer use only)	

Coverage Plan Choice*
Select which plan you want to enroll in
Dental Plans 15009 <input type="checkbox"/> High Option Dental Plan - One Person (D211/5) - \$54.57 <input type="checkbox"/> High Option Dental Plan - Two Persons (D21/5) - \$105.67 <input type="checkbox"/> Regular Option Dental Plan - One Person (D111/5) - \$45.00 <input type="checkbox"/> Regular Option Dental Plan - Two Persons (D112) - \$86.50 <input type="checkbox"/> I want to decline Dental coverage*
Vision Plans 15009 <input type="checkbox"/> Cigna Vision Premium Option Plan - One Person (V211/5) - \$20.08 <input type="checkbox"/> Cigna Vision Premium Option Plan - Two Persons (V212) - \$26.73 <input type="checkbox"/> Cigna Vision Standard Option Plan - One Person (V111/5) - \$14.27 <input type="checkbox"/> Cigna Vision Standard Option Plan - Two Persons (V112) - \$18.42 <input type="checkbox"/> I want to decline Vision coverage*

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*Hallmark eligibility rules dictate coverage options available. If a retiree/spouse is already Medicare eligible and enrolled please check two person coverage. If you decline any coverage for which you are eligible for, you will not be able to reenroll in that benefit at a later date.

*****SIGNATURE REQUIRED ON THIS PAGE TO ENROLL*****

Payment Options – choose your payment method

- ACH – This is a safe, convenient way to pay your monthly premium without having to write a check. Include a voided check and we will deduct your monthly premiums from your account.**
- Direct Bill – Bills are typically sent the 1st week of each month for coverage effective the next month.**

Signature and Date

I hereby certify that the above information is true and complete. I understand any misrepresentation contained herein may result in exclusion from Hallmark Retiree Medical Plan. I also acknowledge that Mercer and/or Hallmark may release my information to CIGNA as is necessary solely for the purpose of treatment, payment claims and general health care operations.

X _____
Retiree/Surviving Spouse Signature (Required)

Date

X _____
Spouse Signature (Required if covered)

Date

Please mail the completed form to: Mercer Health & Benefits Administration LLC, PO Box 14464, Des Moines, IA 50306-3464

For customer service: call 877-228-9061, Monday through Friday, 7:00 am to 5:00 pm Central Time.