2024 HALLMARK ENROLLMENT FORM

Please complete this 2-sided enrollment form.

Retiree/Surviving Spouse Information

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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 ☐ Female ☐ Male
Social Security Number (CIGNA/Mercer use only)	

Coverage Plan Choice*

Select which plan you want to enroll in

Dental Plans 15009

- ☐ High Option Dental Plan - One Person (D211/5) - $60.63
- ☐ High Option Dental Plan - Two Persons (D21/5) - $117.40
- ☐ Regular Option Dental Plan - One Person (D111/5) - $50.00
- ☐ Regular Option Dental Plan - Two Persons (D112) - $96.11
- ☐ I want to decline Dental coverage*

Vision Plans 15009

- ☐ Cigna Vision Premium Option Plan - One Person (V211/5) - $22.31
- ☐ Cigna Vision Premium Option Plan - Two Persons (V212) - $29.70
- ☐ Cigna Vision Standard Option Plan - One Person (V111/5) - $15.85
- ☐ Cigna Vision Standard Option Plan - Two Persons (V112) - $20.46
- ☐ 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.**

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*****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. Please visit www.mercermyaccount.com and to set up your account and update your ACH information.**

- ☐ **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: Hallmark Retiree Service Center, 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.

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