2021 HALLMARK ENROLLMENT FORM

Please complete this 2-sided enrollment form and return it to Mercer in the enclosed self-addressed envelope.

Retiree/Surviving Spouse Information

080533010101

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	Medicare ID Number	Medicare Part A Effective Date	Medicare Part B Effective Date	
Social Security Number (CIGNA/Mercer use only)	If enrolled in Medicare, please include a copy of your Medicare ID Card.			

Spouse Information

Last Name, First Name, Middle Initial		
Birth Date (MM/DD/YYYY)	Gender ☐ Female ☐ Male	
Medicare ID Number	Medicare Part A Effective Date	Medicare Part B Effective Date
Social Security Number (CIGNA/Mercer use only)	If enrolled in Medicare, please include a copy of your Medicare ID Card.	

Coverage Plan Choice*

Select which plan you want to enroll in

Medicare Plans 15009

- ☐ Cigna Medicare Surround Plan Medical Only - One Person (M021/5) - $159.00
- ☐ Cigna Medicare Surround Plan Medical Only - Two Persons (M021/5) - $318.00
- ☐ Cigna Medicare Surround Plan Medical/RX - One Person (MR21/5) - $316.00
- ☐ Cigna Medicare Surround Plan Medical/RX - Two Persons (MR21/5) - $632.00
- ☐ I want to decline Medical/RX coverage. *

Dental Plans 15009

- ☐ High Option Dental Plan - One Person (D211/5) - $54.40
- ☐ High Option Dental Plan - Two Persons (D21/5) - $105.50
- ☐ Regular Option Dental Plan - One Person (D111/5) - $44.83
- ☐ Regular Option Dental Plan - Two Persons (D112) - $86.33
- ☐ I want to decline Dental coverage. *

Vision Plans 15009

- ☐ Cigna Vision Premium Option Plan - One Person (V211/5) - $18.61
- ☐ Cigna Vision Premium Option Plan - Two Persons (V212) - $25.26
- ☐ Cigna Vision Standard Option Plan - One Person (V111/5) - $12.80
- ☐ Cigna Vision Standard Option Plan - Two Persons (V112) - $16.95
- ☐ I want to decline Vision coverage.*

***Hallmark eligibility rules dictate coverage options available. 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 THE BACK OF 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 in the enclosed self-addressed envelope 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.