2021 HALLMARK RETIREE BENEFITS ENROLLMENT FORM – TIER 1

Please complete this 2-sided enrollment form within 30 days of your date of retire.

Retiree/Surviving Spouse Information

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	**Hallmark Employee ID**	**Social Security Number (Mercer use only)**		
Date of Hire		**Date of Retirement**		

Spouse/Domestic Partner Information

Last Name, First Name, Middle Initial	
Birth Date (MM/DD/YYYY)	**Gender** ☐ **Female** ☐ **Male**
Social Security Number (/Mercer use only)	

Coverage Plan Choice*

Select which plan you want to enroll in

Medical Plans 15009

- ☐ **United Healthcare High Deductible Plan – Retiree Only (T011) - $405.17**
- ☐ **United Healthcare High Deductible Plan – Retiree & Spouse (T012) - $1103.46**
- ☐ **United Healthcare High Deductible Plan – Retiree & Domestic Partner (T012) - $1103.46**
- ☐ **United Healthcare High Deductible Plan – Spouse Only (T015) – $699.92**
- ☐ **United Healthcare Traditional Plan - Retiree Only (T111) - $552.54**
- ☐ **United Healthcare Traditional Plan - Retiree & Spouse (T112) - $1457.15**
- ☐ **United Healthcare Traditional Plan - Retiree & Domestic Partner (T112) - $1457.15**
- ☐ **United Healthcare Traditional Plan - Spouse Only (T115) - $906.24**
- ☐ **I want to waive Medical/RX coverage***

Dental Plans 15009

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

***Hallmark eligibility rules dictate coverage options available. You have a one-time option to waive any coverage for which you are eligible for and enroll later. If you cancel coverage after that enrollment, you may not re-enroll in the plan.**

*****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 on the 5th business day each month.**

☐ **Direct Bill – Bills are generated the 1st weekend of each 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 United Healthcare/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**

There are two options to return the enrollment form:

Please mail the completed form to:

Mercer Health & Benefits Administration LLC, PO Box 14464, Des Moines, IA 50306-3464.

Or

Go to www.hallmarkretireebenefits.com for instructions on how to upload this form.

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