



2021 HALLMARK RETIREE BENEFITS ENROLLMENT FORM – TIER 1A

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 <input type="checkbox"/> Female <input type="checkbox"/> 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 (T051) - \$405.17
- United Healthcare High Deductible Plan – Retiree & Spouse (T052) - \$1103.46
- United Healthcare High Deductible Plan – Retiree & Domestic Partner (T052) - \$1103.46
- United Healthcare High Deductible Plan – Spouse Only (T055) – \$699.92
- United Healthcare Traditional Plan - Retiree Only (T511) - \$552.54
- United Healthcare Traditional Plan - Retiree & Spouse (T512) - \$1457.15
- United Healthcare Traditional Plan - Retiree & Domestic Partner (T512) - \$1457.15
- United Healthcare Traditional Plan - Spouse Only (T515) - \$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.