MERCER
MAKE TOMORROW, TODAY

ICE NYSE

INTERCONTINENTAL EXCHANGE/NYSE RETIREE BENEFITS ENROLLMENT FORM

Please complete all sections of this form.

SECTION 1: Personal information: (Please fill out completely)

First Name:		Last Name:
Address:		
City:	State:	Zip:
Home Telephone:	Email:	
Date of Birth:	S.S.#:	If Medicare Eligible Medicare # (From Medicare Card):

SECTION 2: Please check one of the following coverage's: (Choose One)

Retiree		
Medical Under age 65	☐ Anthem PPO	☐ Anthem HDHP ☐ Waive
Medical Over age 65 or Medicare Eligible	☐ Anthem Medicare Eligible Plan	☐ Waive
Dependent(s)		
Medical Under age 65	☐ Anthem PPO	☐ Anthem HDHP ☐ Waive
Medical Over age 65 or Medicare Eligible	☐ Anthem Medicare Eligible Plan	☐ Waive

NOTE: See enclosed rate sheet (if applicable)

SECTION 3: Choose the coverage for yourself and eligible dependents:

Level of Coverage ☐ Individual ☐ Individual plus spouse ☐ Individual plus children ☐ Family

SECTION 4: Please update dependent information and list eligible dependents (including spouse). For spouse or dependent that is Medicare Eligible include Medicare # from Medicare Card

Name	Relationship	Birth date	S.S. #	Medicare # (If applicable)

SECTION 5: Signature & Authorization

I certify that I have read and understand the provisions of the medical plans, as detailed in the ICE/NYSE Enrollment Information Package, and that the information I have provided is true and accurate to the best of my knowledge. I acknowledge receipt of ICE/NYSE notice describing these plans and I agree to the terms and conditions stated therein. I understand that I must remit payment (if applicable) for these benefits on a monthly basis direct to Mercer Health & Benefits LLC either through EFT or remitting payment by check. I also understand that I cannot change my coverage option until the next Open Enrollment period or if I incur a "Life Event". If I waive or terminate any part of my coverage I will not be eligible to re-enroll in the future. Please note, you may not add new dependents but you can drop coverage for dependents.

(Date) (Retiree Signature)

Medical Only