

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	<input type="checkbox"/> Anthem PPO	<input type="checkbox"/> Anthem HDHP	<input type="checkbox"/> Waive
Medical Over age 65 or Medicare Eligible	<input type="checkbox"/> Anthem Medicare Eligible Plan	<input type="checkbox"/> Waive	
Dependent(s)			
Medical Under age 65	<input type="checkbox"/> Anthem PPO	<input type="checkbox"/> Anthem HDHP	<input type="checkbox"/> Waive
Medical Over age 65 or Medicare Eligible	<input type="checkbox"/> Anthem Medicare Eligible Plan	<input type="checkbox"/> Waive	
Dental	MetLife Plan	Waive Dental	

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
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**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)