U.S.W. LOCAL 10-00086 MERCK EMPLOYEES HEALTH & WELFARE FUND
ENROLLMENT / CHANGE FORM
(Please Print)

_____ Change of Address
_____ Name Change
_____ I DO NOT WISH **MEDICAL** COVERAGE AT THIS TIME. (Provide proof of other coverage, i.e. copy of insurance card)
_____ I DO NOT WISH **DENTAL** COVERAGE AT THIS TIME. (Provide proof of other coverage, i.e. copy of insurance card)

I. SSN:_____ WEIN #:_____

Last Name:_____ First Name:_____ Sex:_____

Address: _____ Apt. No:_____

City: _____State: _____ Zip:_____ Date of Birth.:_____

Date of Hire (if new hire) : _____ Home Phone: _____

II. Coverage Available: Horizon BCBSNJ (Medical), Express Scripts Inc. (RX) and VBA (Vision) AND UCCI (Dental)

Medical - Weekly Deduction: Single - $31.00 ☐ Two-Party - $41.00 ☐ Three-Party or More - $50.00 ☐

Dental - Weekly Deduction: Single - $ 3.00 ☐ Two-Party - $ 6.25 ☐ Three-Party or More - $ 9.50 ☐

III. **[ ] ADD DEPENDENT - EFFECTIVE DATE:_____ (CHECK REASON BELOW)**

[ ] MARRIAGE
(Provide copy of Marriage License)

[ ] LOSS of INSURANCE COVERAGE
(Provide proof of loss of coverage)

[ ] Birth of Child (Provide copy of birth certificate)

[ ] Other: _____

[ ] OPEN ENROLLMENT (7/1 ONLY)

NOTE: Adult Child Dependent - Dependents are covered under the plan until the end of the month they turn age 26.

IV. **[ ] REMOVE DEPENDENT - EFFECTIVE DATE:_____**

[ ] REASON: _____ (Provide the following documents relating to the event): If a divorce, provide copy of final divorce decree. If dependent has other coverage, provide proof of other coverage, i.e. copy of spouse's insurance card or a letter from spouse's employer.

CONFIDENTIALITY NOTICE

The information contained in this application is privileged and confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby requested that you should not further distribute or copy this information. In addition, if you have received this information in error, please notify richard Gabriel associates immediately at (800) 610-8300 and destroy all pages received by you in error. Thank you for your compliance.

Revised July 1, 2016

V. Please complete the following information. Provide birth and marriage certificate if adding new spouse, newborn, stepchild, adopted child or foster child.

Add	Remove	Continue	Name (Include last name if different from Applicant) (PLEASE PRINT)	LAST	FIRST	Sex F/M	Date of Birth	Social Security No. *(Mandatory for each dependent)*
			Self					
			Spouse					
			Child					
			Child					
			Child					
			Child					

IMPORTANT - Any newly acquired Dependents (marriage, birth of child, adoption, etc.) are eligible for coverage under the Plan on the date they are acquired, provided that you furnish a completed application to the Plan Administrator within 31 days after the event. If application for enrollment is not received within 31 days after the event, applications will not be accepted until the Plan's Open Enrollment effective date (July 1st of each year). You also may only change your coverage during the Plan's Open Enrollment period (May-June) unless a "Life Event" occurs.

NOTICE REGARDING FRAUDULENT INFORMATION - Any person who knowingly and with intent to defraud any insurance company or other person, submits incorrect information on this application, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VI. Member Signature:_____Date Signed:_____

Plan Administrator: richard Gabriel associates
Attn: Karen Irwin
601 Dresher Road, Suite 201
Horsham, PA 19044
Tel. No.: (215) 773-0900 Fax. No.: (215) 773-9907
Email: kirwin@rgabriel.com

Revised July 1, 2016