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

_____ 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) : _____ Primary Phone Number: _____

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

Medical - Bi-Weekly Deduction: Single - $66.00 ☐ Two-Party - $88.00 ☐ Three-Party or More - $112.00 ☐

Dental - Bi-Weekly Deduction: Single - $ 7.00 ☐ Two-Party - $14.50 ☐ Three-Party or More - $ 21.50 ☐

YOU ARE RESPONSIBLE TO ASSURE YOUR PAYROLL CONTRIBUTIONS ARE BEING DEDUCTED AND ARE CORRECT. IF YOU DO NOT PAY THE REQUIRED EMPLOYEE CONTRIBUTION YOU WILL BE RESPONSIBLE TO REPAY ANY RETRO AMOUNT OWED TO THE FUND.

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

[ ] **MARRIAGE** (Provide copy of Marriage License

[ ] **BIRTH OF CHILD** (Provide copy of birth certificate)

[ ] OPEN ENROLLMENT (7/1 ONLY)

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

[ ] **Overage Dependent** (Provide proof of loss of other coverage)

NOTE: Adult Child 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 (for spouse or dependents under the age of 18).

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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:_____

Benefits Administrator:

Karen Irwin
Fax No: (215) 773-9907
Email: kirwin@rgabriel.com
Tel. No.: (215) 773-0900

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