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Mercer Marketplace 365+SM

Open Enrollment/Change Form

Please fill out this enrollment form and have it postmarked, faxed or emailed no later than the open enrollment end date.

Section 1: Qualified Beneficiary (QB) Information

Social Security Number | Last Name | First Name

Street Address | City | State | Zip

Phone Number | Date of Birth (mm/dd/yyyy) | Change Effective Date (mm/dd/yyyy) | Open Enrollment End Date (mm/dd/yyyy)

Employer Name

Section 2: Dependent/Type of Coverage Information

Please put an "A" for Add or "D" for Delete in the box under Type of Coverage to indicate if you would like to add or delete that QB or dependent from that type of coverage. All fields must be completed if electing a level of coverage other than "Single." Omitting any information will delay the reinstatement of coverage for you and any applicable dependents. Please refer to the enclosed information for the type of coverage available to you. List all persons to be enrolled/terminated.

	Last Name	First Name	MI	Sex (M/F)	Date of Birth (mm/dd/yyyy)	Social Security Number	Type of Coverage Med | Dental | Vision | Other
Qualified Beneficiary							
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

Section 3: Level of Coverage

Please specify the plan and level of coverage. Refer to the enclosed information for the type of coverage available to you.

Medical Plan Name | Medical Level of Coverage (E.g. Single, Single + Spouse, Single + Child(ren), Family)

Dental Plan Name | Medical Level of Coverage (E.g. Single, Single + Spouse, Single + Child(ren), Family)

Vision Plan Name | Medical Level of Coverage (E.g. Single, Single + Spouse, Single + Child(ren), Family)

Other Plan Name | Medical Level of Coverage (E.g. Single, Single + Spouse, Single + Child(ren), Family)

Section 4: Authorization

The information is complete and correct to the best of my knowledge. During the open enrollment period, I authorize Mercer Marketplace to make changes to my benefits that are stated on this form. I understand that any changes postmarked after the open enrollment period will not be honored and therefore my benefits terminate.

Qualified Beneficiary Signature | Date (mm/dd/yyyy)

Spouse Signature (Only required if coverage is being terminated for the spouse but not Primary QB) | Date (mm/dd/yyyy)