

**Mercer Auglaize Employee Benefit Trust  
MINSTER SCHOOLS  
Enrollment/Change Form**

(Please Print Legibly)

<b>FOR OFFICE USE ONLY</b>	
<input type="checkbox"/> <b>New Enrollment</b>	Effective Date - (MM/DD/YY) / /
<input type="checkbox"/> <b>Change:</b> Effective Date:    /    /    Reason for Change:	Pay \$

<b>1. EMPLOYEE INFORMATION</b>		<b>Office Location</b>	<b>Date of Hire - (MM/DD/YY)</b> / /
Last Name	First Name (Or Initial)	Middle Name (Or Initial)	Previous Last Name (If Applicable)
Home Address		City	State    Zip Code
Date of Birth - (MM/DD/YY) / /	Sex <input type="radio"/> Male <input type="radio"/> Female	Home Phone (    ) -    -	Social Security Number -    -

Marital Status-check appropriate box(es) and furnish date. If ever divorced and are enrolling dependents from that marriage, please see your local HR contact.

<input type="checkbox"/> Never Married	<input type="checkbox"/> Married-Date:	<input type="checkbox"/> Widowed-Date:
<input type="checkbox"/> Legally Separated-Date:	<input type="checkbox"/> Divorced-Date:	<input type="checkbox"/> Remarried-Date:

<b>2. MEDICAL PLANS</b>				<b>3. DENTAL PLAN</b>			
Choose One Coverage Type →	<input type="checkbox"/> First Dollar (B6352) <input type="checkbox"/> Comp A (B6636) <input type="checkbox"/> PPO (B8948) <input type="checkbox"/> No Medical Coverage	Choose One Coverage Level →	<input type="checkbox"/> Individual  <input type="checkbox"/> Family	Choose One Coverage Type →	<input type="checkbox"/> Dental (B4114) <input type="checkbox"/> Dental (B7422) PPO <input type="checkbox"/> No Dental Coverage	Choose One Coverage Level →	<input type="checkbox"/> Individual  <input type="checkbox"/> Family

<b>4. PRESCRIPTION DRUG PLAN</b>				<b>5. VISION PLAN</b>			
Choose One Coverage Type →	<input type="checkbox"/> P Drug (B3342) <input type="checkbox"/> No P Drug Coverage	Choose One Coverage Level →	<input type="checkbox"/> Individual  <input type="checkbox"/> Family	Choose One Coverage Type →	<input type="checkbox"/> Vision  <input type="checkbox"/> No Vision Coverage	Choose One Coverage Level →	<input type="checkbox"/> Individual  <input type="checkbox"/> Family

Please complete and check the appropriate insurance coverage for each dependent. List all eligible dependents you want covered on benefit selections.  
NOTE: If you need more room for your dependents, please attach an additional sheet of paper to this form.

Status	Name: Last, First, MI	Relationship	Medical	Dental	Date of Birth	Sex	Student	Social Security #
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dep 1					MM / DD / YY / /	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No	-    -
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dep 2					MM / DD / YY / /	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No	-    -
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dep 3					MM / DD / YY / /	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No	-    -
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dep 4					MM / DD / YY / /	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No	-    -
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dep 5					MM / DD / YY / /	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No	-    -

**5. OTHER HEALTH INSURANCE INFORMATION**

Do you or any of your family members have other Group Health and/or Dental Insurance (including Medicare)?  YES  NO

If yes, name of insured person		Social Security #
Name of Employer	Address of Employer	
Insurance Company/Medicare	Medical Policy # _____ _____	Dental Policy # _____ _____
Dependents covered:	Medical _____ _____	Dental _____ _____

**Please Note:** Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

I hereby consent and authorize any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any information regarding the medical records concerning myself or a member of my family to CoreSource, Inc. for the purpose of supervising and monitoring the health plan(s). This consent shall be valid until revoked, in writing, by me.

**Attach HIPAA Certificates of Coverage (if applicable) for employee and/or dependents that you have received for previous coverage from other medical plans.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date