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

☐ 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)
☐ Change of Address
☐ Name Change

I. SSN: _____ WEIN #: _____ Date of Hire: _____

Date of Birth: _____ Primary Phone Number: _____ Gender [M/F/O]: _____

Last Name: _____ First Name: _____

Address: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

II. Coverage and **Bi-Weekly** Deductions: **Horizon BCBSNJ (Medical). Express Scripts (Rx), VBA (Vision) and UCCI (Dental)**

Medical /RX/Vision -	Single - $77.40	☐	Two-Party - $103.18	☐	Three-Party or More - $131.34 ☐
Dental -	Single - $ 8.19	☐	Two-Party - $ 16.97	☐	Three-Party or More - $ 25.16 ☐

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

III. **ADD DEPENDENT - EFFECTIVE DATE: _____ (CHECK REASON BELOW)**
LIFE EVENT:

- ☐ **MARRIAGE** (Provide copy of Marriage Certificate)
- ☐ **BIRTH OF A CHILD** (Provide copy of birth certificate)
- ☐ **OPEN ENROLLMENT (7/1 ONLY)**
- ☐ **LOSS of INSURANCE COVERAGE** (Provide proof of loss of coverage)
- ☐ **ADULT DEPENDENT** (Provide proof of loss of other coverage)
  Note: Adult Child Dependents are covered under the plan until the end of Month they turn age 26.

IV. **REMOVE DEPENDENT - EFFECTIVE DATE: _____ (DISCLOSE REASON BELOW)**

REASON: _____ (Provide the following documents relating to event): If a divorce - final divorce decree. If dependent has other coverage, provide proof of other coverage (for spouse or dependents under the age of 18).

Revised January 1, 2025

V. Complete the following information. Provide birth and/or marriage certificate if adding a new spouse or dependent child.

Add	Remove	Continue	Name (Include last name if different from Applicant) (PLEASE PRINT)	LAST	FIRST	Gender M/F/O	Date of Birth	Social Security No.
			Self					
			Spouse					
			Child					
			Child					
			Child					
			Child					

IMPORTANT – Any new Dependents (via marriage, birth of a child, adoption, etc.) are eligible for coverage under the Plan on the date they become dependents, provided that you furnish a completed application to the Plan Administrator within 30 days after the life event. If application for enrollment Is not received within 30 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 change your coverage during the Plan's Open Enrollment period (May-June).

NOTICE REGARDING FRAUDULENT INFORMATION – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VI. Member Signature: _____ Date Signed: _____

Return completed form and attachments to your RAE Consulting Benefits Administration Team:	**RAE Consulting** **601 Dresher Road, Suite 201** **Horsham, PA 19044**	**Fax – 215-773-9907 or** **USWHealth@rae-consulting.net**

Revised January 1, 2025