



Retiree + Child

Instructions: Please complete all sections highlighted in "yellow".



Under 65 Enrollment Form

Carriers: Aetna (Medical, Prescription Drug, and Dental) and VSP (Vision)
Please complete in Ink and check the applicable boxes () below

Section I: Tell us about the retiree.

Last name	First name	M.I.	Date of birth
Address	City	State	Zip code
Daytime telephone number	Social Security Number		Sex (M or F)
Retirement Date	Email Address		

Section II: List Spouse and/or All Dependents That Are Enrolling – *** Relationship code S (Spouse) SS (Surviving Spouse) DP (Domestic Partner) C (Child by birth or adoption) D (Disabled child)

Name (First, MI, Last)	Relationship Code***	Sex	Date of Birth	Full-Time Student	SSN
	C				

Section III: Important Notes To Help You Correctly Select and Complete Your Coverage Election.

- 1) You can find a complete listing of your 2011 rates on the included enrollment worksheet. Please review these rates before selecting your coverage.
- 2) If you are not electing the Premium or Standard Bundled Plans you must also check the box separately if you want Dental and Vision Coverage.
- 3) When selecting your coverage please check each box that pertains to the coverage you are electing. For example – if you are selecting the Premium Plan for both Retiree and Spouse you will need to check both the Retiree and Spouse box. If you are selecting the Premium Plan for both Retiree and Child you will need to check both the Retiree and Child box.
- 4) Family Coverage is coverage including retiree and 2 more individuals.
- 5) Spouse and child(ren) enrolling as Qualified Family Members should check both the Spouse and Child(ren) box
- 6) Please review all information and sign and date where necessary.

Section II Instructions: Please list the name, relationship, sex, date of birth, student status, and social security number for dependents enrolling for coverage.



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Section IV: Select Your Coverage			
Effective Date for Coverage <u>1</u> /01/2011 You MUST select an Effective Date to start coverage			
Premium Plan (Bundled Medical, Prescription Drug, Dental, and Vision):			
<input checked="" type="checkbox"/> Retiree <small>PB01/VB01 RS PB02/VB02 RC PB04/VB04</small>	<input type="checkbox"/> Spouse <small>PB05/VB05 SC PB06/VB06 PB08/VB08</small>	<input checked="" type="checkbox"/> Child(ren) <small>PB07/VB07</small>	<input type="checkbox"/> Family <small>PB03/VB03</small>
Standard Plan (Bundled Medical, Prescription Drug, Dental, and Vision):			
<input type="checkbox"/> Retiree <small>SB01/VB01 RS SB02/VB02 RC SB04/VB04</small>	<input type="checkbox"/> Spouse <small>SB05/VB05 SC SB06/VB06 SB08/VB08</small>	<input type="checkbox"/> Child(ren) <small>SB07/VB07</small>	<input type="checkbox"/> Family <small>SB03/VB03</small>
Dental: Without a Medical Plan			
<input type="checkbox"/> Retiree <small>D101/ RS D102/ RC D104</small>	<input type="checkbox"/> Spouse <small>D105/ SC D106 D108</small>	<input type="checkbox"/> Child(ren) <small>D107</small>	<input type="checkbox"/> Family <small>D103</small>
Vision: Without a Medical Plan			
<input type="checkbox"/> Retiree <small>V101/ RS V102/ RC V104</small>	<input type="checkbox"/> Spouse <small>V105/ SC V106 V108</small>	<input type="checkbox"/> Child(ren) <small>V107</small>	<input type="checkbox"/> Family <small>V103</small>

If any family members enrolling in this plan are enrolled in Medicare please, complete the below information:

Name _____ Medicare Number _____ Effective Date: _____
 Name _____ Medicare Number _____ Effective Date: _____

Retiree Signature: _____ Retiree Signature _____ Date: _____ Date _____
 (If Enrolling)

Spouse Signature: _____ Date: _____
 (If Enrolling)

This enrollment form must be completed in it's entirety before coverage can be issued. Any missing information will delay your enrollment in being processed. Coverage will be effective the first of the month upon receipt of the completed enrollment form.

Please return your completed enrollment form and the first month's premium payment to:
 Marsh, a service of Seabury & Smith
 PO Box 14464
 Des Moines, IA 50306

Please make your check payable to DP3 VEBA Trust

Section IV Instructions: Please select an effective date for coverage to begin. Please select your coverage choices utilizing the boxes above. Premium and Standard plans include Dental and Vision. You will not need to select Dental and Vision separately if choosing the Premium or Standard plan. Otherwise you will need to select Dental, Vision, or both separately. The example provided above has been filled out for enrollment in the Premium Plan.

Please remember to sign and date the form. Please mail the form including the first month's payment to Marsh at the address noted above.