Internal Use only	Client Name: DP3 VEBA Trust
	DP3 Health Plan Number:

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.

			month day year
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

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 <u>not</u> 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 IV: Select Your Coverage.

Effective Date for Coverage: ____/01/2011 You MUST select an Effective Date to start coverage

Premium Plan (Bundled Medical, Prescription Drug, Dental, and Vision):

☐ Retiree	☐ Spouse	☐ Child(ren)	☐ Family
PB01/ VB01 RS PB02/VB02 RC PB04/VB04	PB05/ VB05 SC PB06/VB06 PB08/VB08	PB07/VB07	PB03/VB03

Standard Plan (Bundled Medical, Prescription Drug, Dental, and Vision):

☐ Retiree	☐ Spouse	☐ Child(ren)	☐ Family
SB01/ VB01 RS SB02/VB02 RC SB04/VB04	SB05/ VB05 SC SB06/VB06 SB08/VB08	SB07/VB07	SB03/VB03

Dental: Without a Medical Plan

☐ Retiree	☐ Spouse	☐ Child(ren)	☐ Family
D101/ RS D102/ RC D104	D105/ SC D106 D108	D107	D103

Vision: Without a Medical Plan

☐ Retiree	☐ Spouse	☐ Child(ren)	☐ Family
V101/ RS V102/ RC V104	V105/ SC V106 V108	V107	V103

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: _____ 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