



MERP Enrollment Form



EMPLOYER INFORMATION

Employer Name: Austal, USA, LLC

Please mail, e-mail or fax completed form to:

Sheryl Wainwright
100 Addsko Road
Mobile, AL 36602

TELEPHONE: 251-445-7388
EMAIL: Sheryl.wainwright@austalusa.com

I am enrolling in the MERP for (Please check one): Self Only Self & Child(ren) Child(ren) Only Spouse Only
 Self & Spouse Self & Family Spouse & Child(ren)

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date Eligible for MERP:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security No:	Spouse's Employer:	

*** If the other coverage is a HDHP and your spouse is not enrolled in the MERP, your spouse may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the MERP. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the MERP. Also, if your primary health coverage is through Medicare, Tricare or Medicaid, you are not eligible for the MERP.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored MERP. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for MERP benefits. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am not eligible to participate in the MERP offered through my employer.**

Employee Signature:

Date: