BENEFITS ENROLLMENT FORM

Name:	Date of Hire:
SSN#:	Birth Date:
Address:	Effective Date:
City & State:	Zip:

Reason: ☐ **NEW HIRE** ☐ **LIFE EVENT** ☐ **OPEN ENROLLMENT**

Instructions: Please complete, sign, date and return this enrollment form to the Human Resources Department no later than 30 days post hire. Please Note: Once your enrollment form has been submitted and processed, no changes will be allowed during the current plan year except in the case of a qualifying event. All deductions will be taken each pay period on a pre-tax basis unless otherwise denoted.

Illinois Monthly Contribution Rates

1. Medical Plan
☐ **Yes** ☐ **No/Waive (If No, complete Section 2)**

*Rates listed below are Wellness Rates – Non-Wellness rates are $41.66 higher
** Rates do not include the Spouse Surcharge or the Tobacco Surcharge

Medical Plan Options	Single	Employee + Spouse or D/P	Employee + Child(ren)	Employee + Family
BCBS HMO Illinois	☐ $156.33	☐ $345.98	☐ $333.29	☐ $514.67
BCBS PPO Illinois	☐ $437.00	☐ $805.53	☐ $774.24	☐ $1230.14
BCBS HSA Illinois	☐ $277.90	☐ $468.42	☐ $441.12	☐ $709.29

Reason for Waiving Medical Coverage:

<u>BCBS HMO Blue Advantage- Must fill out</u>
Medical Group/IPA# __________________________ & Medical Group IPA Name_______________________________
PCP#____ & PCP Name: ____

WPHCP Medical Group Name______________________ & WPHCP (Physician)#______________________________
WPHCP (physician) Name _________________________

2. Dental Plan ☐ **Yes** ☐ **No/Waive**	Single	Employee + Spouse or D/P	Employee + Child(ren)	Employee + Family
Delta Dental	☐ $44.55	☐ $89.10	☐ $102.24	☐ $150.03

3. Vision Plan ☐ **Yes** ☐ **No/Waive**	Single	Employee + Spouse or D/P	Employee + Child(ren)	Employee + Family
Superior Vision	☐ $9.16	☐ $15.70	☐ $16.02	☐ $25.80

4. Covered Member(s) Selection

List dependents to be covered under elected plans

Participant Name *First Name and Last Name*	**SSN#**	**Gender**	**DOB**	**Relationship**
Spouse or D/P:				
Child:				
Child:				
Child:				
Child:				

5. Section 125 Flexible Spending Plans

	Plan Option	**Max Contribution**	**Election**
1	Health Care FSA	$2750 maximum per year	$ per year
2	Limited Purpose FSA (with/HSA)	$2750 maximum per year	$ per year
3	Dependent Care	$5000 maximum per year	$ per year
4	HSA Deferral	$3550 Single ($4550 over age 55)	$ per year
	*HSA limits are for the current year	$7100 Family ($8100 over age 55)	$ per year

☐ I understand that any elections made for Options 1, 2 & 3 are irrevocable until the next plan year open enrollment except in the event of a major life change as defined by the IRS described in the enrollment packet and that any money remaining in the dependent day care account I set up will be forfeited 90 days after the day year ends.

6. Authorization: All employees must read, sign and date this section

Please sign, date and return enrollment form to the Human Resource Department as soon as possible.

My signature on this form confirms that I have received the benefit plan information provided by the employer and/or any changes made to the plans. I certify that all information provided to the employer for benefit enrollment is true, correct and complete. I acknowledge that my coverage is subject to cancellation or other action permissible by law if any completed information is found to be false or incorrect. I agree to abide by each insurer's enrollment provisions, including their designated administrators. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I authorize payroll deduction of premiums as required to pay for benefit elections. I further understand that pre-tax benefit elections may only be altered at open enrollment and/or due to a qualifying change in employment or family status. Coverage changes must be made within 30-days of a qualified life event. The group policies set forth all terms of my coverage. In the event of a discrepancy between the information provided by the employer and the benefit plan provisions, the policy or plan documents and insurance contracts will govern. No rights shall accrue to you and/or your dependents because of any statement, error or omission in the documents provided by your employer. I further understand that the plans may be terminated or amended at any time.

Your Signature: ____ **Date:**______________________________