SECTION 1. Employee Information

Full Name (Last, First, MI)	Social Security #	Birth Date

Home Address (Number, Street, Apt #)	City	State	Zip Code

Phone #	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced

DATE OF HIRE:	JOB TITLE: ANNUAL EARNINGS:	☐ New Hire ☐ Open Enrollment ☐ Qualifying Event ☐ Termination Effective Date: _____

SECTION 2. Coverage Election

BLUE CROSS BLUE SHIELD MEDICAL		BCBS DENTAL	VISION
☐ PPO 250 [Classifed & Custodial Staff] ☐ PPO 1000 [Administrative & Certified Staff] ☐ PPO HDHP w/HSA ☐ HMO Illinois* ☐ BlueAdvantage HMO* **If electing HMO you must complete section 4*	☐ Employee Only ☐ Employee + Dependent(s) ☐ I am declining / waiving medical coverage	☐ Employee Only ☐ Employee + Dependent(s) ☐ I am declining / waiving dental coverage	☐ Employee Only ☐ Emp + spouse ☐ Emp + child/children ☐ Emp + family ☐ I am declining / waiving vision coverage

SECTION 3. Eligible Dependents

Add	Term	Last Name (If Different)	First Name		Social Security #	Birth Date	Gender (M/F)
				Spouse			
				Child			
				Child			
				Child			
				Child			
				Child			

SECTION 4. HMO ONLY – *YOU DO NOT NEED TO COMPLETE THIS SECTION UNLESS YOU ARE ELECTING HMO*

Member's First Name	Primary Care Physician (PCP) Name	PCP's Phone Number	PCP # *(9-digit # from BCBS website)*	Medical Group # *(3-digit # from BCBS website)*
Employee				
Spouse				
Child				
Child				
Child				
Child				
Child				

SECTION 5. Employer Paid Benefits *(Eligible employees will automatically be enrolled in the coverage below, at no cost to the employee.)*

☑ Basic Life/Accidental Death & Dismemberment - $20,000 – PLEASE COMPLETE SECTION 8

☑ Teladoc – Telehealth Services

SECTION 6. Long Term Disability [LTD]

Benefit: 60% of salary up to $6,000 per month

Certified Staff is automatically enrolled on Long Term Disability and payment deducted per pay period.

All others must apply for coverage. Completing an enrollment form does not guarantee coverage.

See Carol Canada in the Business Office if interested in applying.

SECTION 7. Voluntary Life – Coverage is NOT guaranteed. Evidence of Insurability is Required for All Benefit Elections.

Add (A), Change (C), Delete (D)	Individual Requesting Coverage:	Indicate amount of Voluntary Life	Is Evidence of Insurability Required? Yes or No		If (C) Change, list Prior Coverage
	□ Employee	$	Yes	**UPON PROCESSING THIS ENROLLMENT, YOU WILL RECEIVE AN EMAIL PROVIDING A LINK TO COMPLETE AND SUBMIT YOUR EVIDENCE OF INSURABILITY STATEMENT.**	
	□ Spouse	$	Yes		
	□ Child/Children	$	Yes		

SECTION 8. Life Insurance Beneficiary Designation

Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple primary beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.
Contingent Beneficiary means the person or person who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death.
Dependent Beneficiary – In the event a dependent dies, the employee is the beneficiary of their life insurance proceeds.

Primary Beneficiary Name	Relationship	Birth Date	Address	%
Contingent Beneficiary Name	**Relationship**	**Birth Date**	**Address**	**%**

SECTION 9. Authorization

***I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with West Chicago Elementary School District #33. I authorize my employer to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization will be in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage. Medical, dental and vision insurance deductions are paid on a pre-tax basis unless a waiver form is submitted.*

Employee's Signature: _____ Date: _____

SECTION 10. Waiver of Coverage

You have the option to waive coverage under the West Chicago Elementary School District #33 health plan. In deciding to waive coverage you should be aware of the following information:

- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must request to enroll in your plan within 30 days of losing the other coverage.
- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

Please note: **If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.**

I acknowledge that the Employer has offered me the opportunity to enroll myself and my eligible dependents in the West Chicago Elementary School District #33 health plan, during the plan year beginning January 1, 2022 through December 31, 2022, and I am choosing to decline the coverage.

I decline to apply for group coverage because of:
□ Spousal coverage □ Medicare supplement □ Individual coverage □ Parent's cover me □ Other _____

I have read the information above. I understand the consequences of my waiver of coverage.

Employee's Signature: **Date:**