



# Benefit Election & Waiver Form

EIN: 36-6006668

Please complete the following election form for your benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Forest Preserve District of Will County and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form and sign/ date at the bottom of the back page. You must provide a reason for waiving coverage.

Open Enrollment       New Hire       Change of Status\*       Waiving All Coverage\*\*

\*Qualifying Event \_\_\_\_\_ \*\*Reason for Waiving \_\_\_\_\_

*\*Change of Status is only applicable if you have experienced a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*

*\*\* Please note that all employees will be enrolled in employer sponsored Basic Life & AD&D.*

Client Name:	Forest Preserve District of Will County	Social Security #:	_____
Employee Name:	_____	Date of Hire:	_____
Address:	_____	Coverage Effective:	_____
City, State, Zip:	_____	Telephone #:	_____
Date of Birth:	_____	Gender:	_____
		Marital Status:	_____

## Medical Coverage I choose to waive medical coverage for myself and my dependents BCBSIL

	HMO BA B30712	PPO HDHP 230713	
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	Note: Fill out dependent information below if you elect a tier other than Employee Only.  <b>*If you select HMO, you must fill out the Medical PCP information on the back of this form.</b>
Employee + Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
Employee + Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	
Family	<input type="checkbox"/>	<input type="checkbox"/>	

## Dental Coverage Election I choose to waive dental coverage for myself and my dependents BCBSIL

	Low Plan 230715	
Employee Only	<input type="checkbox"/>	Note: Fill out dependent information below if you elect a tier other than Employee Only.
Employee + Spouse	<input type="checkbox"/>	
Employee + Child(ren)	<input type="checkbox"/>	
Family	<input type="checkbox"/>	

## Vision Coverage Election I choose to waive vision coverage for myself and my dependents VSP

	Vision Plan 30082920	
Employee Only	<input type="checkbox"/>	Note: Fill out dependent information below if you elect a tier other than Employee Only.
Employee + Spouse	<input type="checkbox"/>	
Employee + Child(ren)	<input type="checkbox"/>	
Family	<input type="checkbox"/>	

**Dependent Information—Medical, Dental, and/or Vision Elections**

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision

**Medical PCP Information—Complete only if electing medical HMO** **EIN: 36-6006668**

Name of Enrolled Employee or Dependent	Medical PCP Name & ID Number	Medical Group Name & Number

**Basic Life / AD&D Beneficiaries—\$25,000** **The Hartford**

Primary Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
				%
				%
				%

Total (must equal 100%)	<b>100%</b>
-------------------------	-------------

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
				%
				%
				%

Total (must equal 100%)	<b>100%</b>
-------------------------	-------------

## Voluntary Life / AD&D Coverage

The Hartford

- I choose to **elect** Voluntary Life coverage (indicate amount below)       I choose to **waive** Voluntary Life coverage
- I choose to **elect** Voluntary AD&D coverage (must elect Voluntary Life & be equal to the Voluntary Life election amount)       I choose to **waive** Voluntary AD&D coverage

**MANDATORY: Please provide an email address if electing Voluntary Life/AD&D:**

Type	Benefit Amount Offered	Guarantee Issue Amount	Voluntary Life Coverage Elected	Voluntary AD&D Coverage Elected*
Employee	Elect a maximum of \$500,000 in \$10,000 increments	\$250,000	\$	\$
Spouse	Elect a maximum of \$250,000 in \$5,000 increments	\$50,000	\$	\$
Child(ren)	Elect a maximum of \$10,000 in \$2,000 increments	\$10,000	\$	\$

\*If electing Voluntary AD&D, the election must be equal to the Voluntary Life election.

**NOTE:** You must complete the Evidence of Insurability form if (1) You or your spouse previously waived or did not enroll when you first became eligible; (2) You have elected to purchase more than **\$250,000** for Employee Coverage; (3) You have elected to purchase more than **\$50,000** for Spouse Coverage; You must purchase coverage for yourself in order to purchase coverage for your spouse and/or child(ren). Late entrants and amounts over the Guarantee Issue are subject to underwriting approval. Coverage will begin on the first of the month following approval. In some instances, a physical exam by a doctor may be required. A spouse's maximum election cannot exceed 50% of the employee's election amount.

### Voluntary Life/AD&D Rate Chart

Age Band	Employee / Spouse Monthly Rates** per \$1,000 of Coverage	Age Band	Employee / Spouse Monthly Rates** per \$1,000 of Coverage	Additional Monthly Rates per \$1,000 of Coverage
<24	\$0.055	50-54	\$0.275	AD&D (all ages) \$0.030
25-29	\$0.065	55-59	\$0.455	
30-34	\$0.080	60-64	\$0.780	Child(ren) Life \$0.200
35-39	\$0.095	65-69	\$1.270	Child(ren) AD&D \$0.030
40-44	\$0.120	70-74	\$2.300	
45-49	\$0.180	75+	\$3.720	

\*\*Spouse Rate is based on employee age.

## Voluntary Life/AD&D Beneficiaries

The Hartford

Primary Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
				%
				%
				%
Total (must equal 100%)				<b>100%</b>

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
				%
				%
				%
Total (must equal 100%)				<b>100%</b>

## Authorization and Signature

Your next opportunity to make changes will be during the next open enrollment period, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact your local Human Resources representative within 30 days of the life status change.

**My signature below authorizes Forest Preserve District of Will County to deduct insurance premiums on a pre-tax basis.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_