# GIN 2020-2021 Benefit Election & Waiver Form

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 City of Elmhurst 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. ***There will be another open enrollment period for 1/1/2021.***

☐ **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.*

Company Name: City of Elmhurst

Employee Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: / /

Gender: _____

Social Security #: — —

Date of Hire: _____

Coverage Effective: / /

Telephone #: — —

Marital Status: _____

## Medical Coverage

☐ I choose to waive medical coverage for myself and my dependents **BCBSIL**

| | HMO | PPO 300 | PPO HDHP |
|---|---|---|---|
| Employee Only | ☐ | ☐ | ☐ |
| Employee + Spouse | ☐ | ☐ | ☐ |
| Employee + Child(ren) | ☐ | ☐ | ☐ |
| Family | ☐ | ☐ | ☐ |

Note: Fill out dependent information below if you elect a tier other then Employee Only.

***If you select HMO, you must fill out the Medical PCP information on the back of this form.**

## HSA Banking

☐ I choose to waive funding my HSA with pre-tax dollars **Fifth Third Bank**

Bank Name: Fifth Third Bank

Amount Electing per Pay Period: $ _____

Note: Fill out HSA election only if you elect the HDHP plan.

| Your HSA Bank Account with Further: | Employee Only | Family |
|---|---|---|
| City of Elmhurst Contribution | $1,400 | $2,800 |
| You can contribute up to an additional | $2,150 | $4,300 |
| Maximum IRS Annual HSA Contributions 2020 | $3,550 | $7,100 |
| Catch-Up Contribution (Age 55+) | Additional $1,000 | |

## Dental Coverage Election

☐ I choose to waive dental coverage for myself and my dependents **BCBSIL**

| | CORE Plan | Low Plan | High Plan |
|---|---|---|---|
| Employee Only | ☐ | ☐ | ☐ |
| Employee + Spouse | ☐ | ☐ | ☐ |
| Employee + Child(ren) | ☐ | ☐ | ☐ |
| Family | ☐ | ☐ | ☐ |

Note: Fill out dependent information below if you elect a tier other then Employee Only.

## Vision Coverage Election

☐ I choose to waive vision coverage for myself and my dependents **VSP**

| | Vision Plan |
|---|---|
| Employee Only | ☐ |
| Employee + Spouse | ☐ |
| Employee + Child(ren) | ☐ |
| Family | ☐ |

Note: Fill out dependent information below if you elect a tier other then Employee Only.

## 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

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

## Basic Life / AD&D Beneficiaries — Dearborn National

**Eligible to all employees that are enrolling in employer Basic Life/AD&D**

| Primary Beneficiary Full Name | Address | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | % |
| | | / / | | % |
| | | / / | | % |
| Total (must equal 100%) | | | | % |

| Contingent Beneficiary Full Name | Address | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | % |
| | | / / | | % |
| | | / / | | % |
| Total (must equal 100%) | | | | % |

## Voluntary Life / AD&D Coverage — Dearborn National

☐ I choose to **elect** Voluntary Life/ AD&D coverage (indicate amount below) ☐ I choose to **waive** Voluntary Life /AD&D coverage

| Type | Benefit Amount Offered | Guarantee Issue Amount | Life 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 | $ |

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

## Voluntary Life/AD&D Beneficiaries — Dearborn National

| Primary Beneficiary Full Name | Address | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | % |
| | | / / | | % |
| | | / / | | % |
| Total (must equal 100%) | | | | % |

| Contingent Beneficiary Full Name | Address | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | % |
| | | / / | | % |
| | | / / | | % |
| Total (must equal 100%) | | | | % |

## 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 City of Elmhurst to deduct insurance premiums on a pre-tax basis.**

Name: _____ Signature: _____ Date: / /