ILLINOIS SCHOOL
Insurance Network

Community Consolidated School District 181

Enrollment / Change Checklist

Employee Name:	
Reason for Enrollment / Change:	☐ New Hire ☐ Birth ☐ Job Status Change ☐ Marriage ☐ Lost Other Coverage ☐ Other | Describe:_____ ☐ Open Enrollment
Coverage Elected	
Medical Insurance BCBS of IL	☐ Enrolled in PPO ☐ Enrolled in HMO ☐ Confirm Medical Group # provided on application ☐ Enrolled in HDHP ☐ Waived Medical
Dental Insurance BCBS of IL	☐ Enrolled in Dental ☐ Waived Dental
Vision Insurance VSP	☐ Enrolled in Vision ☐ Waived Vision

Employee Salary:_____

Benefit Class:_____

Employees: Please submit along with all other required forms to your HR Department contact.

HR Department: Please submit along with all other required forms to:

Illinois School Insurance Network

Email: mwil.isinadministration@marshmma.com

Benefit Election & Waiver Form

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 181

EIN: 36-6004536

Please complete the following election form for your benefits. Select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered, and are therefore waiving all coverage, please check the box for waiving coverage under each benefit. The top portion of this form must be completed in its entirety. Form is not valid unless signed.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Retirement** ☐ **Qualifying Life Event* (Please Describe)** _____

**Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. See Angela Rangel with questions.*

REQUIRED INFORMATION

Employee Name: _____ Social Security #: ___ ___

Address: _____ Date of Hire: / /

City, State, Zip: _____ Coverage Effective: / /

Date of Birth: / / Gender: ☐ M ☐ F Telephone #: ___ ___

Marital Status: _____

Email: _____

Medical Coverage Election

☐ I choose to waive medical coverage for the plan year. **BCBS of Illinois**

	HMO 3** B14332	HMO 4** B01776	PPO 294492	HDHP 294504
Employee Only	☐	☐	☐	☐
Employee + Spouse*	☐	☐	☐	☐
Employee + Child(ren)*	☐	☐	☐	☐
Family*	☐	☐	☐	☐

*Fill out dependent information below if you elect a tier other than Employee Only.

****If you select HMO, you must provide a Medical Group # and PCP Information on the next page.**

If enrolling in the BCBS of IL medical plan, you will be automatically enrolled in the same tier of the VSP vision plan at no cost to you.

Dental Coverage Election

☐ I choose to waive dental coverage for the plan year. **BCBS of Illinois**

	Dental DPPO 308195
Employee Only	☐
Employee + 1	☐
Family*	☐

*Fill out dependent information below if you elect a tier other than Employee Only.

Vision Coverage Election

☐ I choose to waive vision coverage for the plan year. **VSP**

	Vision 12019596
Employee Only	☐
Employee + Spouse*	☐
Employee + Child(ren)*	☐
Family*	☐

*Fill out dependent information below if you elect a tier other than Employee Only.

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
	___ ___	/ /					
	___ ___	/ /					
	___ ___	/ /					
	___ ___	/ /					
	___ ___	/ /					

Medical PCP Information

THIS INFORMATION IS REQUIRED IF ENROLLING IN MEDICAL HMO PLAN

Name of Enrolled	Medical PCP Name	9-Digit PCP ID Number	3-Digit Medical Group/ IPA Number

Voluntary Accident Insurance

☐ I choose to waive this coverage for the plan year.

BCBS of Illinois

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Family ☐

Voluntary Hospital Indemnity Insurance

☐ I choose to waive this coverage for the plan year.

BCBS of Illinois

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Family ☐

Voluntary Critical Illness Insurance

BCBS of Illinois

☐ I choose to **elect** Critical Illness coverage (indicate amount below)

☐ I choose to **waive** Critical Illness coverage

Elect Coverage Amount

Employee	☐ $5,000	☐ $15,000	
	☐ $10,000	☐ $20,000	
Spouse	☐ $2,500	☐ $7,500	
	☐ $5,000	☐ $10,000	Date of Birth: ___/___/___
Child(ren)	☐ $2,500	☐ $7,500	
	☐ $5,000	☐ $10,000	

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. 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 Angela Rangel within 30 days of the life status change.

My signature below authorizes Community Consolidated School District 181 to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: ___/___/___