EIN: 36-6009349

GIN **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 Village of Romeoville, 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: Village of Romeoville		Social Security #:
Employee Name:		Date of Hire:
Address:		Coverage Effective:
City, State, Zip:		Telephone #:
Date of Birth:	Gender:	Marital Status:
Email:		

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

	HMO BA B05096	BCO PPO 300 305948	PPO 300 PH0015	PPO 750 PH0016	HDHP 3500 230713	HDHP 4000 438963
Employee Only	☐	☐	☐	☐	☐	☐
Employee + Spouse	☐	☐	☐	☐	☐	☐
Employee + Child(ren)	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐

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

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

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

	High Plan 230717
Employee Only	☐
Employee + Spouse	☐
Employee + Child(ren)	☐
Family	☐

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

Vision Coverage Election ☐ I choose to vision coverage for myself and my dependents **VSP**

	Vision 30082920
Employee Only	☐
Employee + Spouse	☐
Employee + Child(ren)	☐
Family	☐

Note: Fill out dependent information below if you elect a tier other than 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		EIN: 36-6009349
Name of Enrolled	**Medical PCP Name and ID Number**	**Medical Group Name and Number**

Basic Life / AD&D Beneficiaries - 1x Salary up to $150,000 Eligible to all employees that are enrolling in employer Basic Life/AD&D				The Hartford
Primary Beneficiary Full Name	**Address**	**Date of Birth**	**Relationship**	**Benefit %**
				%
				%
				%
Total (must equal 100%)				100%
Contingent Beneficiary Full Name	**Address**	**Date of Birth**	**Relationship**	**Benefit %**
				%
				%
				%
Total (must equal 100%)				100%

Voluntary Life / AD&D Coverage (Employee is responsible for the full cost of premium) **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 and be equal to Voluntary Life 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 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; (4) you have elected to purchase any amount of coverage for your child(ren) that previously waived or did not enroll when you first became eligible. 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. The rate for dependent children is $0.46 per $2,000 of coverage, and covers all eligible children.

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%)				100%

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

Voluntary Accident Insurance	☐ I choose to waive Accident coverage for myself and my dependents		The Hartford
	Plan 1	**Plan 2**	**Plan 3**
Employee Only	☐	☐	☐
Employee + Spouse	☐	☐	☐
Employee + Child(ren)	☐	☐	☐
Family	☐	☐	☐

Voluntary Hospital Indemnity Insurance	☐ I choose to waive Hospital Indemnity for myself and my dependents		The Hartford
	Plan 1	**Plan 2**	**Plan 3**
Employee Only	☐	☐	☐
Employee + Spouse	☐	☐	☐
Employee + Child(ren)	☐	☐	☐
Family	☐	☐	☐

Voluntary Critical Illness Insurance — The Hartford

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

Employee	☐ $10,000	☐ $20,000	☐ $30,000
Spouse	☐ $10,000	☐ $20,000	☐ $30,000

Note: Child(ren) coverage is included in Employee Coverage

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 Village of Romeoville to deduct insurance premiums on a pre-tax basis.

Name:_____ Signature:_____ Date:_____