



☐ Open Enrollment ☐ New Hire ☐ Qualifying Event [Event: _____ / Date of Event: _____]

Library Name:	_____	Section Number:	_____
Employee Name:	_____	Date of Hire:	_____/_____/_____
Address:	_____	Social Security #:	____-____-____
City, State, Zip:	_____	Telephone #:	____-____-____
Date of Birth:	____/____/____	Marital Status:	_____
Gender:	_____		

[illegible]

Carrier: Blue Cross Blue Shield of IL

	HMO	PPO 750	PPO 1500	HDHP/HSA
Employee Only	☐	☐	☐	☐
Employee + Spouse	☐	☐	☐	☐
Employee + Child(ren)	☐	☐	☐	☐
Family	☐	☐	☐	☐

☐ I choose to waive medical coverage for myself and my family.

Carrier: Blue Cross Blue Shield of IL

	DHMO*	DPPO
Employee Only	☐	☐
Employee + Spouse	☐	☐
Employee + Child(ren)	☐	☐
Family	☐	☐

*If selecting DHMO, Dental PCP information is required below.

☐ I choose to waive dental coverage for myself and my family.

[illegible]

Vision Coverage Election

Carrier: VSP

Vision Plan

Employee Only ☐

Employee + Spouse ☐

Employee + Child(ren) ☐

Family ☐

Note: Dependent information required if electing a tier other than Employee Only.

☐ I choose to waive vision coverage for myself and my family.

Basic Life / AD&D Beneficiaries - \$30,000 Benefit

Carrier: The Hartford

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

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

Voluntary Life / AD&D Coverage

Carrier: The Hartford

☐ 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	Life/AD&D Coverage Elected
Employee	Up to 5x salary not to exceed \$300,000 in \$10,000 increments	\$150,000	\$
Spouse	Maximum of \$150,000 in \$5,000 increments, not to exceed 50% of employee's elected and approved amount	\$50,000	\$
Child(ren) 15 days to 26 years	Elect a maximum of \$15,000 in \$5,000 increments	\$15,000	\$

Vol Life/AD&D Rate Chart (Monthly Rates)

Age Band	Employee Rate per \$10,000	Spouse Rate per \$5,000	Age Band	Employee Rate per \$10,000	Spouse Rate per \$5,000	Child Rate per \$5,000
<24	\$0.81	\$0.41	50-54	\$3.21	\$1.61	\$1.00
25-29	\$0.91	\$0.46	55-59	\$5.41	\$2.71	
30-34	\$1.11	\$0.56	60-64	\$7.31	\$3.66	
35-39	\$1.21	\$0.61	65-69	\$13.01	\$6.51	
40-44	\$1.31	\$0.66	70-74	\$26.11	\$13.06	
45-49	\$2.01	\$1.01	75+	\$39.91	\$19.96	

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 **\$150,000** 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.

Voluntary Accident Coverage**Carrier: The Hartford****Accident Plan**

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

Note: Dependent information required if electing a tier other than Employee Only.

☐ I choose to waive voluntary accident coverage for myself and my family.

Voluntary Hospital Indemnity Coverage**Carrier: The Hartford****Hospital Indemnity Plan**

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

Note: Dependent information required if electing a tier other than Employee Only.

☐ I choose to waive voluntary hospital indemnity coverage for myself and my family.

Voluntary Critical Illness Coverage**Carrier: The Hartford****\$10,000****\$20,000**

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

Note: Dependent information required if electing a tier other than Employee Only.

☐ I choose to waive voluntary critical illness coverage for myself and my family.

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 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.

Name: _____ Signature: _____ Date: ____ / ____ / ____