2026 **Benefit** Election & Waiver Form

Please complete the following election form for your 2026 benefits and select the appropriate reason below for completing this form. If you choose not to enroll in any of the benefits offered by LIMRiCC and are therefore waiving all coverage, please check the box for waiving coverage in each section.

☐ **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: ____ / ____ / ____ Gender: ______ Marital Status: ____________

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision	ACC	CI	HI
	— —	/ /								
	— —	/ /								
	— —	/ /								
	— —	/ /								
	— —	/ /								
	— —	/ /								

Medical Coverage Election — Carrier: Blue Cross Blue Shield of IL

	HMO	PPO 1000	PPO 2000	HDHP/HSA
Employee Only	☐	☐	☐	☐
Employee + Spouse	☐	☐	☐	☐
Employee + Child(ren)	☐	☐	☐	☐
Family	☐	☐	☐	☐

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

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

Dental Coverage Election — Carrier: Blue Cross Blue Shield of IL

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

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

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

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

Dental PCP Information

*Name of Enrolled	Dental PCP Name	Center Number (2 letters + 7 digits)

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: **ONE TIME OPEN ENROLLMENT EVENT:**

During LIMRiCC's 2025 annual enrollment, employees and dependents can enroll up to the guarantee issue amount without EOI, including those who missed their first opportunity for a 01/01/2026 effective date.

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: ____/____/____