LIMRiCC
The Library Insurance Management and Risk Control Combination

Election Form

Please complete the following election form for your 2027 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 LIMRiCC, 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.*
***Effective January 1st, 2027, all LIMRiCC employees must be offered Basic Life and AD&D regardless of waiving coverage.*

Library Name:	Social Security # – –
Employee Name:	Date of Hire:
Address:	Coverage Effective:
City, State, Zip:	Telephone #:
Date of Birth: / /	Gender: / Marital Status:
Personal Email Address:	
Job Title:	Salary:

Medical Coverage Election

	PPO 1000	PPO 1500	PPO 2000	HDHP	HMO
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.**

Other Coverage Elections

	DPPO 1000	DPPO 1500	DHMO	Vision Plan A	Vision Plan B (Former WIN)
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 DHMO, you must fill out the Medical PCP information on the back of this form.**

Dependent Information							
Name	**Social Security #**	**Birth Date**	**Gender**	**Relationship**	**Medical**	**Dental**	**Vision**
	_ _	/ /					
	_ _	/ /					
	_ _	/ /					
	_ _	/ /					
	_ _	/ /					
	_ _	/ /					

Medical / Dental PCP Information				
Name of Enrolled	**Medical PCP Name and ID Number**	**Medical Group Name and Number**	**Dental PCP Name and ID Number**	**Dental Group Name and Number**

Basic Life / AD&D Coverage (Effective 01/01/2027 All LIMRiCC Employees must be offered this)	
☐ I choose to **elect** Basic Life / AD&D coverage ($30,000)	☐ I choose to **elect** Basic Life / AD&D coverage ($50,000)

Voluntary Life / AD&D Coverage (Employee is responsible for the full cost of premium)				
☐ 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**	**AD&D Coverage Elected**
Employee	Elect a maximum of $300,000 in $10,000 increments	$150,000	$	$
Spouse	Elect a maximum of $150,000 in $5,000 increments	$50,000	$	$
Child(ren)	Elect a maximum of $15,000 in $5,000 increments	$15,000	$	$

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. The rate for dependent children is $0.021 per $1,000 of coverage, and covers all eligible children.

Voluntary Life Rate Chart			
Age	**Employee/Spouse Rate Per $1,000**	**Age**	**Employee/Spouse Rate Per $1,000**
<24	$0.06	50-54	$0.30
25-29	$0.07	55-59	$0.52
30-34	$0.09	60-64	$0.71
35-39	$0.10	65-69	$1.28
40-44	$0.11	70-74	$2.59
45-49	$0.18	75+	$3.97

Hospitality Indemnity Election		**Accident Election**	
Employee Only	☐ $18.34	Employee Only	☐ $10.70
Employee + Spouse	☐ $35.83	Employee + Spouse	☐ $16.86
Employee + Child(ren)	☐ $31.05	Employee + Child(ren)	☐ $17.90
Family	☐ $50.64	Family	☐ $28.16

Critical Illness Election

☐ I choose to **elect** Critical Illness **(Non-Smoker)**		☐ I choose to **elect** Critical Illness **(Smoker)**	
Age	**Employee Rate Per $10,000**	**Age**	**Employee Rate Per $20,000**
<24	$3.79	<24	$6.62
25-29	$4.60	25-29	$8.15
30-34	$5.14	30-34	$9.19
35-39	$6.48	35-39	$11.84
40-44	$8.97	40-44	$16.72
45-49	$13.73	45-49	$26.14
50-54	$19.00	50-54	$36.31
55-59	$25.87	55-59	$50.24
60-64	$36.30	60-64	$70.99
65-69	$49.68	65-69	$97.56
70-74	$66.71	70-74	$131.52
75-79	$88.95	75-79	$175.90
80+	$107.21	80+	$212.38

Voluntary Disability Coverage (Applicable to Select Libraries)

☐ I choose to **elect** Voluntary Short Term Disability (STD) coverage	☐ I choose to **waive** Voluntary STD coverage
☐ I choose to **elect** Voluntary Long Term Disability (LTD) coverage	☐ I choose to **waive** Voluntary STD coverage

NOTE: *You must complete the* ***Evidence of Insurability*** *form if you previously waived this coverage. Late entrants are subject to underwriting approval. Coverage will begin on the first of the month following approval. A waiting period may apply for pre-existing conditions. Contact HR for assistance in determining your premium and benefit amounts.*

Use the following formula to calculate your semi-monthly cost for STD:

_____	÷ 52	_____	X 70%	_____	÷ 10 =	_____	x	_____	= $	_____
Your Annual Salary		Your Weekly Salary		Weekly Benefit Max = $800				Rate		Semi-Monthly Cost

Use the following formula to calculate your semi-monthly cost for LTD:

_____	÷ 12	_____	X 60%	_____	÷ 100 =	_____	x	_____	= $	_____
Your Annual Salary		Your Weekly Salary		Monthly Benefit Max = $3,000				Rate		Semi-Monthly Cost

Basic Life / AD&D Beneficiaries				
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		
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 for a 1/1/2027 effective date, 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 LIMRiCC to deduct insurance premiums.**		
Name: _____	Signature: _____	Date: _____