BENEFITS ENROLLMENT/CHANGE FORM • COOK COUNTY EMPLOYEE HEALTH BENEFITS

County Building • Employee Benefits Division • Room 1072 • 118 N. Clark Street • Chicago, IL 60602-1304
312-603-6385 (phone) • 866-729-3040 (toll-free fax) • risk.mgmt@cookcountyil.gov (email)

INSTRUCTIONS: Complete and sign this form. Make a copy for your records. Return to the Employee Benefits Division. Print clearly using a pen.

Remember: Please review the plan options and requirements at cookcountyrisk.com. New hire health, dental, and vision benefits begin on the first day of the month following employment date, if application is received within 31 days. All family members must be covered under the same plans under the same employee enrollment. Benefits end on the last day of the month in which the employee is employed. COBRA must begin on the first day of the month following the end of active coverage. New hires must submit dependent documents with this form. For qualifying life events, dependent documentation must be submitted within 45 days. You must complete and return this form within 31 days of your date of hire, or of a qualifying life event that permits a change in coverage.

EMPLOYEE INFORMATION

Social Security #_____ Last Name_____ First Name_____ MI_____

Address_____ Apt. #_____ City/State_____ ZIP Code_____

Home/Cell Phone_____ Work Phone_____ Employee ID #_____ Dept. #_____

Birth Date_____ Employment Date _____ Married: ❑ Yes ❑ No Marriage Date_____ Gender: ❑ Male ❑ Female

Union: ❑ Yes ❑ No If yes, Union Name and Number_____

Employee Email _____

PLAN ELECTION

Check the box by the plan(s) of your choice. If you are a new employee and a member of a union, you must choose the medical HMO and dental HMO for the first year of employment.

Medical	Dental	Vision
❑ Blue Advantage HMO – Medical Group # _____ (employee)	❑ Dental HMO	❑ Vision Plan
❑ Blue Cross PPO	❑ Dental PPO	

If you select the HMO, you must select a primary doctor/dentist. Medical HMO members will not receive an ID card until BCBS receives your medical group number.

DEPENDENT ENROLLMENT

Last Name	First Name	Relationship to You	Gender	Birth Date	Social Security #	HMO Medical Group #
			M / F			
			M / F			
			M / F			
			M / F			

CHANGE INFORMATION

To be completed by employee. Check items as appropriate.

TYPE OF CHANGE

❑ New Employee
❑ Reinstatement
❑ Add Dependent Date of event _____
❑ Delete Dependent Date of event _____
❑ Terminate Insurance

COBRA INFORMATION ISSUED?

❑ Yes ❑ No Date _____

EFFECTIVE DATE_____

Comments (Employee Benefits Staff Only)_____

_____

_____

Initials	Date

CERTIFICATION

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I authorize the deduction of the applicable rate necessary for payment of my health coverage and agree to pay all applicable out-of-pocket expenses including deductible, coinsurance and copayments. I authorize my doctors, hospital or other provider of medical services to make available to the claims administrator any and all medical records pertaining to myself and my dependents, if any. I also release to the claims administrator any information regarding the medical treatment and benefits for myself and any dependents for the purpose of reviewing medical treatment, validating and determining benefits, as well as for plan administration.

Employee Signature_____ Date Signed_____