CITY COLLEGES of CHICAGO

Benefit Enrollment Form

Active Employees: Qualifying Life Event

Personal Information – If you enroll in a HMO medical plan, you MUST indicate your network Primary Care Physician (PCP), Woman's Principal Health Care Provider (WPHCP), if applicable, and their contracting Medical Group name and number. Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group.

SSN#	Last	First	MI

Street Address	City	State	ZIP

Email Address	Home Phone	Cell Phone
	( )	( )

Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Not Married	Birth Date (mm/dd/yy)	Hire Date (mm/dd/yy)

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	WPHCP's Name (must be in same Medical Group as PCP)
__ __ __			

Coverage Election

PLAN: ☐ BlueAdvantage HMO ☐ BCBS PPO ☐ Dental ☐ Vision ☐ HMO Illinois (1600 only)

Complete Family Information. HMO Enrollees: Each family member may select a different contracting Medical Group, PCP, and WPHCP (Woman's Principal Health Care Provider). Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group. For additional dependents, please complete another enrollment form.

Coverage				
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __

Health Flexible Spending Account

☐ Enroll ☐ Change ☐ Decline

I. Contribution Amount:

II. Number of regular pay periods:

III. Contribution/pay period (I divided by II):

Dependent Care Flexible Spending Account

☐ Enroll ☐ Change ☐ Decline

I. Contribution Amount:

II. Number of regular pay periods:

III. Contribution/pay period (I divided by II):

Please continue to the second page

Life and Disability Plans

Group AD&D	Company-Paid Benefit	
EE - Optional Life	☐ Yes ☐ No	☐ **1x salary** ☐ **2x salary** ☐ **3x salary** ☐ **4x salary** ☐ **5x salary** Guaranteed Issue amount of 3x salary (newly eligible) $750,000 maximum coverage
EE - Optional Accidental Death and Dismemberment	☐ Yes ☐ No	☐ **1x salary** ☐ **2x salary** ☐ **3x salary** ☐ **4x salary** ☐ **5x salary** Guaranteed Issue amount of 3 x salary (newly eligible) $750,000 maximum coverage (must enroll in optional EE life)
Spouse - Optional Life	☐ Yes ☐ No	Coverage amount $ _____ (Increments of $10,000) Guaranteed Issue amount of $100,000 $250,000 maximum coverage
Spouse - Optional Accidental Death and Dismemberment	☐ Yes ☐ No	Coverage amount $ _____ (Increments of $10,000) Guaranteed Issue amount of $100,000 $250,000 maximum coverage (must enroll in optional spouse life)
Child - Optional Life	☐ Yes ☐ No	☐ **$10,000** ☐ **$25,000**
Child - Optional Accidental Death and Dismemberment	☐ Yes ☐ No	☐ **$10,000** ☐ **$25,000** (must enroll in optional child life)
Short-Term Disability	☐ Yes ☐ No	60% of weekly pre-disability earnings up to $1,000
Long-Term Disability	☐ Yes ☐ No	65% of monthly pre-disability earnings up to $8,000
Critical Illness - Employee	☐ Yes ☐ No	☐ **$15,000** ☐ **$30,000**
Critical Illness - Spouse/Domestic Partner	☐ Yes ☐ No	☐ **$15,000** ☐ **$30,000**
Critical Illness - Child(ren)	☐ Yes ☐ No	☐ **$15,000** ☐ **$30,000**

Other Group Health Insurance Information – If you or any member of your family have other group health insurance please provide the following.

Insured's Name	Employed By	Birth Date (mm/dd/yy)	Policy Number

Insurance Company Name	Address	City	State	ZIP

I elect coverage under the above-selected Plan(s) on behalf of myself and the above-listed dependents, and authorize any payroll deductions required.

I certify that all information furnished by me on this application is true and complete to the best of my knowledge.

I understand that the services listed in the health insurance certificates will be available, subject to the Term and Conditions thereof, beginning with hospital admissions or medical care rendered, on or after the coverage date set by each insurance carrier.

I understand that I must provide documentation validating an Eligible Dependent's status.

I understand that insurance carrier use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

I understand that I will not have the opportunity to change or cancel my medical plan until the next Open Enrollment period (unless it is within 31 calendar days of a qualifying family status change).

This authorization is to remain in effect until my written notification to the contrary.

Signature of Employee: _____ Date: _____

City Colleges of Chicago
Office of Human Resources
Benefits Division

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