Benefits Enrollment Form
January 1, 2020 – December 31, 2020

TYPE OF ENROLLMENT – OFFICE USE ONLY	Effective date:

❑ Open Enrollment ❑ New Enrollment ❑ Termination ❑ Change – Reason: _____

EMPLOYEE INFORMATION

Name	SSN	Date of Hire:	Date of Birth:
Address ☐ Check if Change	Marital Status ❑ Single ❑ Married	Gender	Department
Email:	Phone:		

ENROLLMENT INFORMATION - Please list those you wish to cover under each plan and indicate coverage selected.

Action	Relation	Name	Social Security #	Date of Birth	Gender	Coverage	Complete if newly electing the HMO	
							Med Group #	PCP #
❑ Continue ❑ Add ❑ Delete	Employee					❑ Medical ❑ Dental ❑ Vision		
❑ Continue ❑ Add ❑ Delete	Spouse					❑ Medical ❑ Dental ❑ Vision		
❑ Continue ❑ Add ❑ Delete	Child 1	❑ Full-time student?*				❑ Medical ❑ Dental ❑ Vision		
❑ Continue ❑ Add ❑ Delete	Child 2	❑ Full-time student?*				❑ Medical ❑ Dental ❑ Vision		
❑ Continue ❑ Add ❑ Delete	Child 3	❑ Full-time student?*				❑ Medical ❑ Dental ❑ Vision		

**You must provide proof of full-time student status in order to enroll an unmarried child age 19 – 26 in the dental and/or vision plans; otherwise you will pay an additional charge (see page 2). Full-time student status is verified annually at open enrollment. It is your responsibility to notify Human Resources in the event of a status change mid-year.*

COORDINATION OF BENEFITS

Are you, your spouse, or children enrolled in Medicare? ❑ Yes (attach copy of Medicare card) ❑ No

Do you, your spouse, or children have other healthcare coverage? ❑ Medical ❑ Dental ❑ Vision

If yes, name of other insurance company or administrator. _____

List all family members enrolled under other plan. _____

WELLNESS PROGRAM INCENTIVE

DuPage County offers a **$20 per month incentive** for employees who participate in the Wellness program. Requirements of the Wellness program include completion of a health risk assessment and biometric screening. If you elect medical coverage and do NOT participate in the Wellness program you will not receive the $20 incentive per month. **New hires have 30 days from their effective date of medical coverage to complete the Wellness program requirements.**

Choose **one** of the following options:
❑ I will participate in the Wellness Program*
❑ I will **NOT** participate in the Wellness Program

*If you elect to participate in the Wellness program and do not complete the requirements, you will be responsible for the higher medical plan cost.

MEDICAL & PRESCRIPTION - Your monthly contribution is listed below (pre-tax deduction); Documentation to verify spouse/child(ren) eligibility is required.

	Single	EE + Spouse	EE + Children	Family
❑ BCBSIL HMO Blue Advantage	❑ $125.60	❑ $278.35	❑ $294.87	❑ $406.34
❑ BCBSIL Blue Edge HSA *To deposit money into an HSA through payroll deductions, please contact Human Resources*	❑ $226.11	❑ $572.06	❑ $549.00	❑ $838.58
❑ BCBSIL Blue Choice PPO	❑ $260.67	❑ $767.96	❑ $736.70	❑ $1,129.24
❑ BCBSIL PPO 1	❑ $274.90	❑ $812.32	❑ $779.19	❑ $1,195.05
❑ **Working Spouse Surcharge** – per the Affidavit, select, if applicable	❑ $100.00			
❑ **Tobacco User Surcharge** – per the Affidavit, select, if applicable	❑ $75.00			
❑ **Medical Opt Out** – per the Affidavit, select, if applicable *You must have a signed Affidavit on file each year in order for the opt out to be payable. If you already have medical coverage through DuPage County, as a dependent, you are not entitled to the $50/month opt out.*	❑ $50.00			

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DENTAL (GROUP # 11256) – Your monthly contribution is listed below (pre-tax deduction)

	Single	EE + Spouse	EE + Children	Family
❑ Delta Dental	❑ $17.00	❑ $47.00	❑ $47.00	❑ $47.00
❑ Illinois House Bill dependent*	❑ $34.30			
❑ I decline Dental coverage				

**Unmarried children who are between the age 19-26 and are not full-time students can be covered under the dental and/or vision plan for an additional charge. Full-time student status is verified annually at open enrollment. This amount will be deducted on a pre-tax basis. It is your responsibility to notify Human Resources in the event of a status change mid-year.*

VISION – Your monthly contribution is listed below (pre-tax deduction)

	Single	EE + Spouse	EE + Children	Family
❑ Superior Vision Plan	❑ $4.33	❑ $10.36	❑ $10.36	❑ $10.36
❑ Illinois House Bill dependent*	❑ $4.33			
❑ I decline Vision coverage				

**Unmarried children who are between the age 19-26 and are not full-time students can be covered under the dental and/or vision plan for an additional charge. Full-time student status is verified annually at open enrollment. This amount will be deducted on a pre-tax basis. It is your responsibility to notify Human Resources in the event of a status change mid-year.*

BASIC LIFE / AD&D INSURANCE - This benefit is provided to you at no cost

☑ The benefit amount is equal to $25,000. Life benefits reduce for employees age 70 and older. This benefit is insured by The Hartford.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts – To enroll for 2020, visit the Discovery Benefits website at www.discoverybenefits.com and follow the steps. If you have any questions during this process, please contact Participant Services at (866) 451-3399. **For new hires effective after January 1st, see Human Resources to enroll.**

OPTIONAL BENEFITS - Additional information can be found on the DuPage County Website, www.dupageco.org

Optional Life (Employee and Dependents) – For additional information, contact Human Resources for an Optional Life Enrollment Kit with The Hartford.

Legal Shield – to cancel, select to the right. **To newly enroll or make a change to your current coverage**, visit www.legalshield.com/info/dupageco.	❑ *Cancel Legal Shield Coverage*
AFLAC Accident & Critical Illness products – to cancel, select to the right. **To newly enroll or make a change to your current coverage**, visit www.aflac.com/dupagecounty. **For new hires effective after January 1st, see Human Resources to enroll.**	❑ *Cancel AFLAC **Accident** Coverage* ❑ *Cancel AFLAC **Critical Illness** Coverage*
Other Supplemental Insurance Products through AFLAC – these plans are no longer available for new enrollments.	❑ *Cancel ALFAC Supplemental Coverage*
Supplemental Insurance Products through Combined Worksite Solutions – these plans are no longer available for new enrollments.	❑ *Cancel Combined Worksite Solutions Supplemental Coverage*

AUTHORIZATION

I have read the information explaining my 2020 benefit choices. I wish to make the choices indicated on this form and authorize DUPAGE COUNTY to make any necessary pre-tax or after-tax payroll adjustments. I understand that these elections are effective January 1, 2020 through December 31, 2020. I understand that I am required to reimburse DUPAGE COUNTY for all elected benefits either during or after any authorized leave.

I understand that this election is irrevocable until next plan year unless there is an allowable change in family status that occurs and I notify Human Resources within 30 days of the allowable change. I certify the information on this form is complete and accurate. Any person who, with intent to defraud or knowing that they are facilitating a fraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

By my signature below I am certifying that the information listed on this form is accurate to the best of my ability. Please note: A person may be committing insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

Signature: Date: