MINOOKA CCSD #201
INSURANCE ENROLLMENT FORM
NON-VESTED w/out Wellness Participation

01/01/2019 -12/31/2019 PLAN YEAR

DATE OF HIRE: _____
EFFECTIVE DATE: _____

Double Premium: _____
Check: _____

_____ _____ _____ ☐ **M** ☐ **F** ☐ **Single** ☐ **Married**
Last Name, First Name, M.I. Birth Date Social Security Number Gender Marital Status

_____ _____ _____
Street Address City/State/Zip Phone Number

☐ **YES,** I want to enroll in the benefits offered by BCBS of IL, Delta Dental and EyeMed. I acknowledge and understand that the reduction will automatically be adjusted in the event of a change in the cost of insurance coverage during the Plan Year.

☐ **NO,** I do not wish to enroll at this time and understand that the opportunity to enroll at any future time will be subject to a qualifying life event or during the next open enrollment with Minooka CCSD #201.

Elections are irrevocable for the Plan Year unless you incur a "Qualifying Event" as described in the Plan.

_____ SINGLE INSURANCE COVERAGE (90/10 Split)

_____ **Traditional PPO** *BB S B / DSB / VSP BES*		_____ **HDHP/HSA** *HDH SB/HSA BS / DSB / VSP BES*	
Medical (BlueCross/BlueShield) *BB SD/NWS*	$50.39	Medical (BlueCross/BlueShield) *HDH SD/NWS*	$42.72
Dental Insurance (Delta Dental) *DSD*	$ 1.70	Dental Insurance (Delta Dental) *DSD*	$ 1.70
Vision Insurance (EyeMed) *VSP DES*	$ .21	Vision Insurance (EyeMed) *VSP DES*	$ .21
Deduction per pay for 24 pays	**$52.30***	**Deduction per pay for 24 pays**	**$44.63***

_____FAMILY INSURANCE COVERAGE (60/40 Split)

_____ **Traditional PPO** *BB NH FB / D FB NV / VSP NH FB*		_____ **HDHP/HSA** *HDH FB NV/HSA BF / D FB NV / VSP NH FB*	
Medical (BlueCross/BlueShield) *BB NH FD/NWF*	$282.74	Medical (BlueCross/BlueShield) *HDH FD NV/NWF*	$232.40
Dental Insurance (Delta Dental) *D FD NV*	$ 11.00	Dental Insurance (Delta Dental) *D FD NV*	$ 11.00
Vision Insurance (EyeMed) *VSP NH FD*	$ 1.39	Vision Insurance (EyeMed) *VSP NH FD*	$ 1.39
Deduction per pay for 24 pays	**$295.13***	**Deduction per pay for 24 pays**	**$244.79***

DEPENDENT INFORMATION FOR FAMILY COVERAGE ONLY (includes spouse)*

Last Name, First, M.I.	SSN #	Relationship	Birthdate

YOU ARE REQUIRED TO SHOW PROOF OF DEPENDENT ELIGIBILTY
YOUR INSURANCE WILL NOT BECOME EFFECTIVE UNTIL THESE DOCUMENTS ARE PROVIDED
MARRIAGE LICENSE (SPOUSAL COVERAGE)
CERTIFIED BIRTH CERTIFICATE (DEPENDENT CHILDREN -biological/adopted/step)
SOCIAL SECURITY CARD (ALL DEPENDENTS)

Employee Signature:_____ Date:_____