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

2024 PLAN YEAR

DATE OF HIRE: _____
Effective Date: _____
Double Prem/Check: _____

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

Home/Mailing Address	**City**	**State**	**Zip**	**County**
		IL		

Best phone number to reach you?	**Email address**

☐	**YES,** I want to enroll in the benefits offered by Minooka CCSD #201. 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.

☐ **SINGLE INSURANCE COVERAGE (90/10 Split)**

☐ **Traditional PPO**		☐ **Value HSA (HDHP)**	
Medical (BlueCross/BlueShield)	$52.00	Medical (BlueCross/BlueShield)	$44.03
Dental Insurance (BlueCare Dental)	$ 1.70	Dental Insurance (BlueCare Dental)	$ 1.70
Vision Insurance (EyeMed)	$ .21	Vision Insurance (EyeMed)	$ .21
Deduction per pay for 24 pays	**$53.91***	**Deduction per pay for 24 pays**	**$45.94***

☐ **FAMILY INSURANCE COVERAGE (60/40 Split)**

☐ **Traditional PPO**		☐ **Value HSA (HDHP)**	
Medical (BlueCross/BlueShield)	$293.25	Medical (BlueCross/BlueShield)	$240.90
Dental Insurance (BlueCare Dental)	$ 11.00	Dental Insurance (BlueCare Dental)	$ 11.00
Vision Insurance (EyeMed)	$ 1.39	Vision Insurance (EyeMed)	$ 1.39
Deduction per pay for 24 pays	**$305.64***	**Deduction per pay for 24 pays**	**$253.29***

DEPENDENT INFORMATION FOR FAMILY COVERAGE ONLY (includes spouse)*

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

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

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

Employee Signature:		**Date:**	