# J. Sterling Morton High School District 201 Health Insurance Enrollment Form

1) **Employee**: please fill out your personal information below and continue to Item 2.

FIRST NAME M.I. LAST NAME SOCIAL SECURITY#

GENDER DATE OF BIRTH PHONE

MAILING ADDRESS CITY ZIPCODE

**2) MEDICAL INSURANCE**

J. Sterling Morton sponsors two different medical plans. If you would like to enroll in one of these plans, please select the appropriate option below. If you are choosing to decline medical insurance coverage, please go to Item 4.

○ BCO (PPO) – BlueCross BlueShield

○ HMO Illinois – BlueCross BlueShield **(REQUIRED 3 DIGIT GROUP NUMBER) Group #_____**

**MEDICAL INSURANCE DEPENDENT ELECTION**

If you would like to cover eligible dependents under your medical insurance plan, please fill in their information below. If you won't be covering any dependents under your medical insurance plan, please go to Item 4.

1

First Name M.I. LAST NAME SOCIAL SECURITY #

DATE OF BIRTH GENDER RELATIONSHIP

2

First Name M.I. LAST NAME SOCIAL SECURITY #

DATE OF BIRTH GENDER RELATIONSHIP

3

First Name M.I. LAST NAME SOCIAL SECURITY #

DATE OF BIRTH GENDER RELATIONSHIP

4

First Name M.I. LAST NAME SOCIAL SECURITY #

DATE OF BIRTH GENDER RELATIONSHIP

***** Please turn over and sign the back page to enroll or waive coverage*******

**4) APPLICATION FOR COVERAGE**

I apply for coverage as indicated above, for which I am or may become eligible. I authorize my employer to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the employer is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available / subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Signature of Employee to be Covered: _____ (MM/DD/YYYY) _____

**5) COVERAGE WAIVED**

I understand that I am eligible or will become eligible for coverage as described above. However, I am electing to waive my right to coverage at this time. I understand that I will not be able to add this coverage until either open enrollment, taking place each month of September with an effective date of October 1st, or when I experience a qualifying event, if I am eligible for such coverage at that time.

- ○ YES, I AM WAIVING BLUE CROSS MEDICAL
- ○ YES, I AM WAIVING AETNA DENTAL
- ○ YES, I AM WAIVING BOTH MEDICAL AND DENTAL

Signature of Employee Waiving Coverage: _____ (MM/DD/YYYY) _____