



BENEFITS WAIVER FORM • COOK COUNTY EMPLOYEE HEALTH BENEFITS
 COUNTY BUILDING • EMPLOYEE BENEFITS DIVISION • ROOM 1072 • 118 N. CLARK STREET • CHICAGO, IL 60602-1304
 312-603-6385 (PHONE) • 866-729-3040 (TOLL-FREE FAX) • risk.mgmt@cookcountyil.gov (EMAIL)

INSTRUCTIONS: Please complete and sign this form as appropriate. Return to Employee Benefits Division. Print clearly, using a ballpoint pen.

EMPLOYEE INFORMATION

Social Security # _____ Last Name _____ First Name _____ MI _____
 Address _____ Apt. # _____ City/State _____ ZIP Code _____
 Home/Cell Phone _____ Work Phone _____ Employee ID # _____ Dept. # _____
 Birth Date _____ Married: Yes No Marriage Date: _____ Sex: Male Female
 Employment Date _____ Union: Yes No If yes, Union Name and Number _____
 Employee Email: _____

WAIVER ELECTION

You have the option of waiving – or “opting out” of – some or all of your County benefits. To do so, check the box(es) that describes your selection(s). If you waive benefits, it does not impact your basic term life insurance benefit.

If you are a spouse or partner of a Cook County Employee, and choose to waive your benefits, all of your coverage is under that employee. You must waive health, dental and vision, maintaining these coverages under the spouse/partner.

				Effective Date
<input type="checkbox"/>	I waive all DENTAL benefits for myself	initial here: _____	and for my dependents	initial here: _____
<input type="checkbox"/>	I waive all VISION benefits for myself	initial here: _____	and for my dependents	initial here: _____
<input type="checkbox"/>	I waive all MEDICAL benefits for myself	initial here: _____	and for my dependents	initial here: _____
	Because (check one):			
<input type="checkbox"/>	My spouse/partner is a Cook County employee and covers me as a dependent on his/her medical plan. My spouse's/partner's Social Security number is: _____			
<input type="checkbox"/>	I have insurance from another source, and have attached proof of coverage (e.g., a copy of the ID card).			

DEPENDENT ENROLLMENT

My medical coverage is outside of Cook County. I want to waive my MEDICAL benefits, but want to keep:

DENTAL benefits (HMO or PPO) for myself initial here: _____ and for my dependents initial here: _____
 VISION benefits for myself initial here: _____ and for my dependents initial here: _____

I understand that my spouse/partner/dependents will be enrolled in the SAME dental and/or vision plan that I'm enrolled in. My dependents are as follows. If you need additional space, please use a second Waiver form.

Last Name	First Name	Relationship SPOUSE/PARTNER	Sex M / F	Birth Date	Social Security #
_____	_____			_____	_____
_____	_____			_____	_____
_____	_____			_____	_____

AUTHORIZATION

Employee Signature _____ Date Signed _____