



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 the Employee Benefits Division. Print clearly using a 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 _____ Employment Date _____ Married: Yes No Marriage Date _____ Gender: Male Female

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 indicate your election(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 family members must be covered under the same plans under the same employee enrollment.

<input type="checkbox"/> I waive all MEDICAL benefits for myself and for my dependents	initial here: _____	Effective Date _____
Reason (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).		
<input type="checkbox"/> I waive all DENTAL benefits for myself and for my dependents	initial here: _____	_____
<input type="checkbox"/> I waive all VISION benefits for myself and for my dependents	initial here: _____	_____

DEPENDENT ENROLLMENT

Enrolling dependents in health benefits plans requires submission of required documentation.

Last Name	First Name	Relationship to You	Gender	Birth Date	Social Security #	HMO Medical Group #
_____	_____	_____	M / F	_____	_____	_____
_____	_____	_____	M / F	_____	_____	_____
_____	_____	_____	M / F	_____	_____	_____
_____	_____	_____	M / F	_____	_____	_____

AUTHORIZATION

Employee Signature _____ Date Signed _____