BENEFITS ENROLLMENT/CHANGE 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)

COBRA

INSTRUCTIONS: Please complete and sign this form. Make a copy for your records. Return to your Timekeeper or to the Employee Benefits Division. Print clearly, using a ball-point pen. **Remember: you must complete and return this form within 31 days of your date of hire, or of a qualifying life event that permits a change in coverage (e.g. marriage, divorce, birth or death of a dependent, etc).** Late submission may result in a delay in coverage effective date.

Employee Information

Social Security #_____ Last Name_____ First Name_____ MI_____

Address_____ Apt. #_____ City/State_____ ZIP Code_____

Home/Cell Phone_____ Work Phone_____ Employee Number_____ Dept._____

Birth Date_____ Employment Date_____ Married: ❑ Yes ❑ No Marriage Date:_____ Sex: ❑ Male ❑ Female

Union: ❑ Yes ❑ No If yes, Union Name/Number_____

Employee Email:_____

Plan Selection

Check the box by the plan(s) of your choice. (If you are a new employee and a member of a union, you must choose a medical and dental HMO for the first year of employment.)

Medical

- ❑ Blue Advantage HMO - Medical Group #_____(employee)
- ❑ Blue Cross PPO
- ❑ Classic Blue HMO **(non-ratified union groups only)** Medical Group #_____ (employee)

Dental

- ❑ Dental HMO
- ❑ Dental PPO

Vision

- ❑ Vision Plan

If you select an HMO, after enrollment, you must select a primary doctor/dentist. Enrollment forms must be received by Risk Management within 31 days. This includes new hires, marriages, births, and civil unions. The marriage/birth/civil union certificates must be received within 45 days of the event.

Continued dependent coverage is contingent upon receipt of documentation.

Dependent Enrollment

Last Name	First Name	Relationship Spouse/Partner	Sex M / F	Birth Date	Social Security #	HMO Medical Group #

Change Information

To be completed by employee. Check items as appropriate.

EFFECTIVE DATE_____

TYPE OF CHANGE

- ❑ New Employee
- ❑ Reinstate Insurance
- ❑ Add Dependent Date of event:_____
- ❑ Delete Dependent Date of event:_____
- ❑ Terminate Insurance

COBRA INFORMATION ISSUED?

❑ Yes ❑ No Date_____

New hire health/dental/vision benefits begin on the first day of the month following the hire date, if application is received within 31 days. Benefits end on the last day of the month in which the person is employed. COBRA must begin on the first day of the month following the end of active coverage.

Comments (Employee Benefits Staff Only)_____

Initials	Date

Authorizations

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I authorize the deduction of the applicable rate necessary for payment of my health coverage and agree to pay all applicable out-of-pocket expenses including deductible, coinsurance and copayments. I authorize my doctors, hospital or other provider of medical services to make available to the claims administrator any and all medical records pertaining to myself and my dependents, if any. I also release to the claims administrator any information regarding the medical treatment and benefits for myself and any dependents for the purpose of reviewing medical treatment, validating and determining benefits, as well as for plan administration.

Employee Signature_____ Date Signed_____