B and B Maintenance

BENEFITS ELECTION FORM – August 1, 2022 to July 31, 2023

(Please complete form in its entirety)

BENEFITS EFFECTIVE DATE:									
New Enrollment:	☐ New Hire	☐ Open Enrollment							
Special Enrollment:	☐ Adoption	☐ Court Order	☐ Dependent Add/Drop	☐ Divorce	☐ Loss/Gain of Coverage				
	☐ Marriage	☐ Newborn	☐ Other:		Date of Event:				

EMPLOYEE PERSONAL INFORMATION					
Last Name:		First Name:		Middle Initial:	
Date of Birth:		Gender:	☐ Male ☐ Female	Social Security #:	
Address:				Apt. #:	
City:		State:		Zip Code:	
Phone #		Email address:			

EMPLOYMENT INFORMATION					
Annual Salary:		Date of **FT** Employment:		☐ Maintenance ☐ Management	
Job Title:		Hours worked per week:		Class if applicable:	

MEDICAL – BlueCross BlueShield of IL		***BI_WEEKLY PRE-TAX* Employee Contributions**
		Blue Choice Options PPO MIBCO2050
Employee Only	☐	☐ $58.00
Employee + Spouse	☐	☐ $356.83
Employee + Child(ren)	☐	☐ $283.24
Full Family	☐	☐ $578.19

☐ Waive Coverage- I choose to waive Medical coverage for this plan year and understand/agree to the waiver acknowledgement

**If you are electing HMO for the first time, please designate your Primary Care Provider (PCP):*				
Employee:	PCP #:		PCP Name:	
Spouse:	PCP #:		PCP Name:	
Child:	PCP #:		PCP Name:	
Child:	PCP#:		PCP Name:	

DENTAL – BlueCross BlueShield of IL		***BI_WEEKLY PRE-TAX* Employee Contributions**
	Dental PPO	☐ Waive I choose to waive Dental coverage for this plan year and understand/agree to the waiver acknowledgement
Employee Only	☐ $18.14	
Employee + Spouse	☐ $ 36.84	
Employee + Child(ren)	☐ $ 46.97	
Full Family	☐ $65.38	

VISION – BlueCross BlueShield of IL		***BI_WEEKLY PRE-TAX* Employee Contributions**
Employee Only	☐ $3.56	☐ Waive I choose to waive Vision coverage for this plan year and understand/agree to the waiver acknowledgement
Employee + Spouse	☐ $7.36	
Employee + Child(ren)	☐ $8.21	
Full Family	☐ $12.94	

EMPLOYER PAID BENEFITS – BlueCross BlueShield of IL	
☒ Short Term Disability – 60% to $125 max. per week	
☒ Life and Accidental Death & Dismemberment (AD&D) $15,000 Benefit	Name your Beneficiaries – must total 100%

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Add/Drop Dependents – Use additional page if necessary				Medical		Dental		Vision	
Name	Social Security #	DOB	M/F	Add	Drop	Add	Drop	Add	Drop

☐ I choose to **WAIVE** the Medical Coverage for this plan year and understand/agree to the following:

You may decline coverage offered by your employer, this is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's plans.

Note that after 2013, if you decline coverage considered affordable and minimum essential under the Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. ***I understand that my employer's plan meets both requirements.***

The decision to waive coverage has consequences for you. For Example:

- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. *You must request to enroll in your Employer's plan within 30 days of losing the other coverage.*
- If you gain a new dependent through birth adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30 day enrollment deadline, you must wait until open enrollment.

I acknowledge that ***my employer*** has offered me affordable minimum essential coverage, as defined under the ACA for the period outlined in this election form. I have read the above and I understand the consequences of my waiver of coverage.

I am declining coverage for the following reason(s): (check all that apply)

☐ Spouse/Domestic Partner's Employer Plan ☐ COBRA/State Continuation ☐ Individual Coverage (Non-Group Plan)

☐ Medicare or other Government Plan ☐ I prefer not to have coverage ☐ Other (please explain):

I authorize the applicable employee rates to be deducted through payroll for the elected coverages. And I realize that my choice will remain unchanged for the entire policy year unless I experience a qualifying event.

Signature:		Date:	
Print Name:			

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BENEFICIARY DESIGNATION

☐ New ☐ Change PLEASE TYPE OR PRINT WITH BALLPOINT PEN

Employee's Name:		**Gender:**	☐ Male ☐ Female
Date of Birth:		**Date of Hire (Full-Time)**	
Social Security Number:			

Irrevocable Beneficiary:	☐ Yes ☐ No

Note: If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract; therefore, the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

BENEFICIARY Must be completed

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. SEE BELOW FOR DETAILS.

	First Name	Last Name	Date of Birth	Social Security #	Relationship	Benefit %
Primary						
Primary						
Contingent						
Contingent						

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia)

Signature of Employee or Member:		Date:	

Important Note for Married Employees: If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, you may name someone other than your spouse as primary beneficiary. However, payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. PRINCIPAL will not be liable for damages due to any delay or dispute in payment of benefits if you choose not to obtain your spouse's signature.

Spousal Consent for Community Property States: I hereby consent to the Primary Beneficiary designation by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature:		Date:		☐ Employee has no legal spouse

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100%

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. If you specify benefit percentages, the total must equal 100%

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, the Insurance Company will pay death benefits in the order of survivorship shown in your group certificate