



BENEFITS ENROLLMENT/CHANGE FORM • COOK COUNTY EMPLOYEE HEALTH CARE PROGRAM

EMPLOYEE BENEFITS OFFICE • ROOM 1072 • COUNTY BUILDING • 118 N. CLARK STREET • CHICAGO, IL 60602

312-603-6385 (PHONE) • 866-729-3040 (TOLL-FREE FAX)



INSTRUCTIONS: Please complete and sign this form as appropriate. Keep the pink copy for yourself; return all other copies to your Timekeeper. Print clearly, using a ball-point pen and pressing firmly, as this form contains multiple copies. Remember: you must complete and return this form within 31 days of your date of hire, or of a qualifying life event that requires a change in coverage (e.g. marriage, divorce, birth or death of a dependent, etc).

EMPLOYEE INFORMATION

Social Security # _____ Last Name _____ First Name _____ MI _____

Address _____ Apt. # _____ City/State _____ ZIP Code _____

Home Phone _____ Work Phone _____ Employee Number _____ Dept. _____

Birth Date _____ Hire Date _____ Married: Yes No Marriage Date: _____ Sex: Male Female

Union: Yes No If yes, Union Name _____

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 an HMO for the first year of employment.)

- H2 HMO Illinois (Blue Cross HMO)
- H3 Unicare HMO
- P2 Blue Cross PPO
- Dental HMO
- Dental PPO
- Vision Plan

If you have selected an HMO, after enrollment, you must call the plan(s) to select a primary doctor/dentist.

Enrollment forms must be received within 31 days. This includes new hires, marriages, births and partnership affidavits. The marriage/birth certificates should follow as soon as possible, within 60 days of the event.

Continued dependent coverage is contingent upon receipt of proper/current documentation.

DEPENDENT ENROLLMENT

Last Name	First Name	Relationship to You	Sex	Birth Date	Social Security #	Disabled?	Full-Time Student?
		SPOUSE/ PARTNER	M / F			Y / N	Y / N
			M / F			Y / N	Y / N
			M / F			Y / N	Y / N
			M / F			Y / N	Y / N

CHANGE INFORMATION

To be completed by employee. Check items as appropriate.

EFFECTIVE DATE _____

TYPE OF CHANGE

- New Employee
- Reinstatement Insurance
- Add Dependent (i.e., marriage, new child)
Date of event: _____
- Delete Dependent (i.e., divorce, death, child no longer eligible)*
Date of event: _____
- Terminate Insurance*
- COBRA

New hire health/dental/vision benefits begin on the first day of the month following the hire date, pending receipt of the application 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.

Special Instructions _____

*COBRA INFORMATION ISSUED?

- Yes No 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 current rate, if any, necessary for payment of my health plan coverage and agree to pay all applicable 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 of the County of Cook and the Forest Preserve District any information regarding the medical treatment and benefits for myself and my dependents, if any, for the purpose of reviewing medical treatment, validating and determining benefits, as well as for auditing and computing statistics.

Employee Signature _____ Date Signed _____