



# BENEFITS WAIVER 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) • 312-603-5909 (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 three copies.

## EMPLOYEE INFORMATION

Social Security # \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City/State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Dept. # \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Married:  Yes  No Marriage Date: \_\_\_\_\_ Sex:  Male  Female  
 Hire Date \_\_\_\_\_ Fund # \_\_\_\_\_ Union:  Yes  No If yes, Union Name \_\_\_\_\_

## 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).

Remember: You may opt out of your own medical benefits, but still enroll your spouse, partner and/or dependents for dental and vision coverage.

- I waive all DENTAL benefits for myself initial here: \_\_\_\_\_ and for my dependents initial here: \_\_\_\_\_  
 I waive all VISION benefits for myself initial here: \_\_\_\_\_ and for my dependents initial here: \_\_\_\_\_  
 I waive all MEDICAL benefits for myself initial here: \_\_\_\_\_ and for my dependents initial here: \_\_\_\_\_

because (check one):

- 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: \_\_\_\_\_  
 I have insurance from another source, and have attached proof of coverage (e.g., a copy of the ID card).

In lieu of my MEDICAL benefits, I am eligible for a payment of \$800, to be (check one):

- Paid to me in one lump-sum check (dependent upon the number of pay periods worked), OR  
 Deposited into a Health Care Flexible Spending Account.

## DEPENDENT ENROLLMENT

I want to waive my MEDICAL benefits, but want to keep:

- DENTAL benefits 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 To You	Sex	Birth Date	Social Security #	Disabled?	Full-Time Student?	Dental HMO Site #
_____	_____	SPOUSE/ PARTNER	M/F	_____	_____	Y/N	Y/N	_____
_____	_____		M/F	_____	_____	Y/N	Y/N	_____
_____	_____		M/F	_____	_____	Y/N	Y/N	_____

## AUTHORIZATION

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_