



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

EMPLOYEE BENEFITS OFFICE • ROOM 925 • 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 gold copy for yourself; return all other copies to your Timekeeper. Print clearly, using a ball-point pen and pressing firmly, as this form contains four 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 ID # _____ Dept. # _____

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

PLAN SELECTION

Check the box by the medical plan of your choice. (If you are a new employee, you **must** select one of the County's HMO options, highlighted in the box at left.) Then, check the box by the number of people you want to enroll in the plan.

HMO OPTIONS

- H1 HumanaHMO Premier
- H2 HMO Illinois (Blue Cross)
- H3 Rush Prudential HMO
- H4 American HMO

POINT-OF SERVICE OPTIONS

- P2 BlueChoice POS (Blue Cross)
- P3 Rush Prudential POS

MEMBERSHIP INFORMATION

- Employee Only
- Employee + 1 Family Member
- Employee + 2 or More Family Members

For all plans: You **must** list the Primary Care Physician (PCP) or Medical Center (not hospital) of choice. Please call the Medical Center within 30 days of enrollment to register with your PCP. For more information, see your plan brochure.

Primary Care Physician Code Number _____ Medical Center Code Number _____

SPOUSE/DEPENDENT ENROLLMENT

Enrollment forms must be received within 31 days. Send certified copies of marriage/birth certificates, partnership affidavits, etc. as soon as possible.

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

EMPLOYEE INFORMATION CHANGE

- Name Change: From _____ To _____
- Department Change: From _____ To _____
- Fund/Account Change: From _____ To _____

EMPLOYMENT STATUS CHANGE

- Taking Leave of Absence (LOA)
- Returning from LOA
- Terminating Employment (last day worked) _____

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 _____

White-Health Care Plan

Yellow-Employee Benefits Office

Pink-Department

Gold-Employee

10/99