CHAMPAIGN COUNTY MEDICAL PLAN ENROLLMENT / STATUS CHANGE FORM

Section 1: EMPLOYEE DEMOGRAPHIC INFORMATION

Last	First	Middle	SSN	Marital Status	Gender

Street Address			Date of Birth	DO NOT WRITE IN THIS BOX
				Date of Hire:
City	State	Zip	Home Phone	Dept:
				Effective Date:

☐ New Enrollment
☐ Status Change

Change Event: | Change Date:

Section 2: MEDICAL PLAN ENROLLMENT (Blue Cross Blue Shield of Illinois PPO Plan)

Select one or complete Waiver section below	☐ EMPLOYEE	☐ EE + SPOUSE	☐ EE + CHILDREN	☐ FAMILY

WAIVER OF COVERAGE	☑ I choose to waive healthcare coverage

Section 3: ELIGIBLE DEPENDENTS (List only those dependents that you wish to enroll in the medical plan)

Eligible dependents are those dependents who are your legal dependents that you can claim on your tax return or who are required to be covered by you under a Qualified Medical Support Court Order. Champaign County may require proof of dependency.
Failure to provide that information may result in dependent being terminated.
Federal laws require Social Security numbers of dependents to be provided.

Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						
Last	First	Middle	Gender	SSN	Date of Birth	Relationship
Address if different:						

THIS FORM IS CONTINUED ON THE REVERSE / PAGE 2

Please turn this form over or turn to Page 2 to answer questions about other insurance or Medicare.

Please sign the form on the reverse side or Page 2 in order to complete the form.

EMPLOYEE DEMOGRAPHIC INFORMATION

Last	First	Middle
Street Address		
City	State	Zip

Section 4: OTHER INSURANCE INFORMATION (NOT MEDICARE)

Are you (or any family members who are to be covered under this plan) going to be covered at the same time under another insurance plan?

☐ YES
☐ NO

If Yes, please complete the information below for any other group or individual insurance plans.

Name (Who is covered?)	Insurance Plan / Carrier	ID Number	Group or Individual	If Group, Employer

Section 5: MEDICARE

Are you (or any family members who are to be covered under this plan) going to be covered at the same time under MEDICARE?

☐ YES
☐ NO

If Yes, please complete the information below.

Name	Medicare HIC#	Medicare Part A Start Date	Medicare Part B Start Date	Due to Disability or ESRD?

Section 6: OTHER NOTES OR COMMENTS

Use this space to continue any information that you do not have room to complete or that needs additional information to describe.

Section 7: SIGNATURE AND AUTHORIZATIONS

I certify that the information above is correct to the best of my knowledge. I understand it is my responsibility to report any change in eligibility of myself or my dependents. I further understand and agree that these changes must be reported within 30 days of the event date in order for me to be able to make the change. I further agree that if I have chosen options which require payroll deductions, I authorize my employer to make the deductions from my pay. My elections will remain in effect until I submit changes. Changes without a life change event can only be made at the Open Enrollment period of my plan. Effective dates of all plan coverages are subject to plan provisons. I agree to be bound by all applicable laws and regulations that pertain to Employee Benefit Plans.
I understand and agree to these statements and enroll or waive coverage for myself and on behalf of all of my eligible dependents.

Signature	Print Name	Date: