BlueCross BlueShield

Illinois Wesleyan University

Employee Benefits Election Form

Office use only
Effective Date:
_____

Sign and return to Kat Jiardina ((309) 556-3971
kjiardin@iwu.edu**), Human Resources Department**

Employee Name:		**Gender:**
Address:	**City:**	**State/Zip:**
SSN#:		**Date of Birth:**
Email:	**Phone:**	**Date of Hire:**

Health Insurance:

BCBSIL Health Plan Options (check only one):

Medical Tier		**Gold**	**Silver**
Employee Only			
Employee + Spouse			
Employee + Child(ren)			
Family			

Signature of Employee to ENROLL:
_____

Date: _____

Dependent Information:

First Name	Mid Int.	Last Name	Spouse or Child	SSN#	M / F	Date of Birth

Are you or any of your dependents covered by another group medical plan? circle one: Yes No
If yes, effective date of coverage: _____
Name of Primary Insured/Policy Holder:_____ DOB: _____
Name of covered dependent(s): _____
ID No.: _____ Name of Insurance Carrier or TPA: _____
Address: _____ Phone: _____
Name of Employer providing coverage: _____
Is Medicare/Medicaid Applicable: ☐ Yes ☐ No
Are you declining due to coverage in another plan? ☐ Yes ☐ No
If Yes, is this other coverage COBRA? ☐ Yes ☐ No

I the undersigned certify that I have been given an opportunity to apply for the group benefit plan offered by Illinois Wesleyan University and after careful consideration have decided to decline to enroll in the coverage hereafter indicated. IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

Signature of Employee to DECLINE: _____ **Date:**