

**CITY OF LINCOLN PARK
ENROLLMENT/WAIVER OF COVERAGE FORM
FOR PLAN YEAR JULY 1, 2016 – JUNE 30, 2017**

Employee Information				
Name (first, middle initial, last)				Social Security Number
Mailing Address (Street)				<input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code	Date of Birth	Phone Number

Coverage	Option	The monthly amount listed below will be split by payroll deduction between two pays
Simply Blue 500	<input type="checkbox"/> elect	<input type="checkbox"/> Single: \$106.51 <input type="checkbox"/> 2 Person: \$255.63 <input type="checkbox"/> Family: \$319.54
Simply Blue 1500	<input type="checkbox"/> elect	<input type="checkbox"/> Single: \$87.98 <input type="checkbox"/> 2 Person: \$211.14 <input type="checkbox"/> Family: \$263.93
Simply Blue HSA	<input type="checkbox"/> elect	<input type="checkbox"/> Single: \$68.08 <input type="checkbox"/> 2 Person: \$163.39 <input type="checkbox"/> Family: \$204.23
Waive Medical Coverage	<input type="checkbox"/> elect	<input type="checkbox"/> \$350 ILO - Only payable if enrolled in other group coverage. Please complete the Waiver of Coverage section of this form on page 2 and attach proof of group coverage with this enrollment form.

IMPORTANT: YOU MUST NOTIFY HUMAN RESOURCES WITHIN 30 DAYS OF ANY QUALIFYING LIFE EVENT. (i.e. marriage, divorce, birth, death, etc.)

Eligible Dependent Information (Complete if you have elected benefits for your spouse and/or children.)

	Check Box	LAST NAME	FIRST NAME	MI	M/F	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY # (Required)
Spouse						/ /	
Dep-1						/ /	
Dep-2						/ /	
Dep-3						/ /	
Dep-4						/ /	

Signature required on page 2

I elect coverage under the benefit plan selected above and authorize the **City of Lincoln Park** (the "Employer") to reduce my salary accordingly by the amount determined as the cost for coverage under such benefit plan that I have elected.

I understand that I cannot change this election and/or salary reduction agreement during the Plan Year, unless otherwise permitted under the terms of the Employer's Plan due to a qualifying event e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment.

This election form and salary reduction agreement revokes any prior election form and salary reduction agreement relating to the Employer's Plan.

Coverage will terminate on my last day of employment and my premium sharing portion will be prorated to reflect the days of coverage.

I will immediately notify the Employer if any information submitted on this election form and salary reduction agreement changes.

Employee Signature _____ **Date** _____

Email Address: _____

**GROUP HEALTH PLAN COVERAGE
WAIVER OF COVERAGE**

For the July 1, 2016 - June 30, 2017 Plan Year

I understand that I am eligible for the benefits provided under the City of Lincoln Park's Medical Plan (the "Plan"). I, however, wish to decline coverage and waive all claims to medical and prescription benefits under the Plan for the Plan Year referenced above. I understand that I need to provide proof of coverage to the City of Lincoln Park.

I understand that I will not be able to choose to enroll for the benefits under the Plan until the next open enrollment period or unless a change of status event occurs due to a qualifying event.

I understand that if I decline health insurance coverage, in order to be eligible to receive the taxable cash payment in lieu of coverage, I must be enrolled in group coverage. Please check the appropriate box above **and** complete the "Waiver of Coverage" section of this form.

The *In Lieu of* (ILO) payment will terminate on my last day of employment and will be prorated accordingly based on the number days worked in the month.

Employee Signature

Email Address

Date: _____