EIN: 36-6005968

Benefit Election & Waiver Form - Retiree

Please complete the following election form for your benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Village of Frankfort and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form and sign/date at the bottom of the back page. You must provide a reason for waiving coverage.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Change of Status*** ☐ **Waiving All Coverage****

***Qualifying Event** ____________ ****Reason for Waiving** ____________

Client Name: Village of Lemont
Social Security #: ____________
Employee Name: ____________
Coverage Effective: ____________
Address: ____________
Date of Birth: ____________
City, State, Zip: ____________
Gender: ____________

Medical Coverage

☐ I choose to waive medical coverage for myself and my dependents — **BCBSIL**

	HMO BA B30712	PPO 750 PH0016	PPO HDHP 230713
Retiree Only	☐	☐	☐
Retiree + Spouse	☐	☐	☐
Retiree + Child(ren)	☐	☐	☐
Retiree Family	☐	☐	☐

Note: Fill out dependent information below if you elect a tier other than Retiree Only.

***If you select HMO, you must fill out the Medical PCP information on the back of this form.**

Dental Coverage Election

☐ I choose to waive dental coverage for myself and my dependents — **BCBSIL**

High Plan 230717

Retiree Only	☐	Retiree + Child(ren)	☐
Retiree+ Spouse	☐	Retiree Family	☐

Note: Fill out dependent information below if you elect a tier other than Retiree Only.

Vision Coverage Election

☐ I choose to waive vision coverage for myself and my dependents — **VSP**

Vision Plan 30082920

Retiree Only	☐	Retiree+ Child(ren)	☐
Retiree+ Spouse	☐	Retiree Family	☐

Note: Fill out dependent information below if you elect a tier other than Retiree Only.

Dependent Information—Medical, Dental, and/or Vision Elections

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

Medical PCP Information—Complete only if electing medical HMO

Name of Enrolled Retiree or Dependent	Medical PCP Name & ID Number	Medical Group Name & Number

Your next opportunity to make changes will be during the next open enrollment period, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.

Name: ____________ Signature: ____________ Date: ____________