O'Fallon CCSD#90
Benefits Election Form – Medical Enrollment 2017
Effective January 1, 2017

Please make your coverage selections below, and sign and return this form to District Office by **December 15th**

If you do not wish to participate in a plan, please check the box marked "waive," sign and return the form.

Employee Name (please print)

I choose the following medical insurance coverage:

Medical Insurance 26 pays	***Medical Insurance 20 pays***
Plan Option 1 –HRA Plan *(26 pays)* ☐ Employee only - $4.57 ☐ Employee & Spouse - $220.03 ☐ Employee & Child(ren) - $199.43 ☐ Family - $232.63	**Plan Option 1 –HRA Plan *(20 pays)*** ☐ Employee only - $5.94 ☐ Employee & Spouse - $286.04 ☐ Employee & Child(ren) - $259.26 ☐ Family - $302.42
Plan Option 2 – *(26 pays)* **High Deductible Plan – NO HRA** ☐ Employee only - $0.00 ☐ Employee & Spouse - $171.78 ☐ Employee & Child(ren) - $152.82 ☐ Family - $180.62	**Plan Option 2 – *(20 pays)*** **High Deductible Plan – NO HRA** ☐ Employee only - $0.00 ☐ Employee & Spouse - $223.31 ☐ Employee & Child(ren) - $198.66 ☐ Family - $234.81
Plan Option 3 – H.S.A *(26 pays)* ☐ Employee only - $0.00 ☐ Employee & Spouse - $62.84 ☐ Employee & Child(ren) - $47.59 ☐ Family - $63.23	**Plan Option 3 – H.S.A *(20 pays)*** ☐ Employee only - $0.00 ☐ Employee & Spouse - $81.70 ☐ Employee & Child(ren) - $61.87 ☐ Family - $82.19

Waive – NO COVERAGE - Please complete back side for WAIVER of Coverage

IMPORTANT→ If you are a new enrollment or adding dependents you will need to complete a BCBS change form in addition to this election form to provide your personal enrollment information. Please contact Cornerstone Insurance Group.

I understand the coverage I have elected is effective January 1, 2017.

Signature Date

Waiver of Group Health Benefits – 2017

Employee Name (PRINT)

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

For the plan year effective ***January 1, 2017 – December 31, 2017***, I am waiving MEDICAL coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

☐ Other _____

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature **Date**

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