COUNTY OF LASALLE
INTERNAL BENEFIT ELECTION FORM
2019

PERSONAL INFORMATION

Last Name	First	Middle	
Address	City	State	Zip Code
Social Security Number	Date of Birth	Date of Hire	Effective Date *(HR use Only)*
Male / Female	Single / Married	Contact Phone Number	

Reason for Enrollment or Change

□ Open Enrollment Election

□ Change in Plan Choice (Describe) _____
(only allowed at Open Enrollment)

□ New Hire/First Time Eligible

□ Add/Delete Dependent

□ Gain/Loss of coverage

□ Change in HSA Contribution _____

DEPENDENT INFORMATION – List your eligible tax dependents whom you wish to enroll for Medical, Dental or Vision. Please submit proof of dependency to the Human Resources Department prior to your effective date. If proper documents (birth certificate / marriage license) are not received, your dependents will not be enrolled in the elected lines of coverage.

Check all that apply

Dependent Name	Birth Date	Soc. Sec. #	Relationship	Gender	Medical	Dental	Vision
Spouse				M ☐ F ☐	☐	☐	☐
Children				M ☐ F ☐	☐	☐	☐
				M ☐ F ☐	☐	☐	☐
				M ☐ F ☐	☐	☐	☐
				M ☐ F ☐	☐	☐	☐
				M ☐ F ☐	☐	☐	☐

Read through each section carefully before making your election
Please complete and return this form to your Human Resources Department

NAME_____

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MEDICAL PLAN (Blue Cross Blue Shield of Illinois) *(Choose an Enrollment Tier OR complete Waiver Area and Sign)*

PPO Plan P92976 ($250 Deductible) □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

PPO Plan PE0601 ($1,500 Deductible) □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

PPO/HSA PE0602 $(3,500 Deductible) □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

□ I decline the **County of LaSalle's** Health Plan

If applying for coverage, are you or any of the covered dependents also covered by other insurance? □ Yes □ No

IF yes, complete the following:
Name of person covered _____ SSN _____ Employer _____

Insurance Company Name and Address _____

MEDICAL PLAN WAIVER. I decline **County of LaSalle's** offer of medical coverage. The reason for my declination of coverage is:

□ Spouse's Employer Plan □ Individual Coverage (Non-Group Plan) □ COBRA/State Continuation
□ Medicare or other Government Program □ Other (please explain) _____

Signature _____ Date _____

*(By choosing to waive medical coverage, you are choosing not to enroll in the medical plan(s) offered by **County of LaSalle**. You will not have an opportunity to enroll in these plans until the next annual open enrollment period unless you notify Human Resources within 30 days of a qualified status change/life event, or within 60 days of loss of Medicaid/CHIP eligibility.*

VOLUNTARY DENTAL PLAN (Delta Dental of Illinois)

(IF ENROLLING, CHOOSE A PLAN AND AN ENROLLMENT TIER)

PPO Low Plan □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

PPO High Plan □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

□ I decline the **County of LaSalle's** Voluntary Dental Plan

Signature _____ Date _____

VOLUNTARY VISION PLAN (VSP – Vision Service Plan)

(IF ENROLLING, CHOOSE AN ENROLLMENT TIER)

PPO Plan □ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family

□ I decline the **County of LaSalle's** Voluntary Vision Plan

Signature _____ Date _____

NAME_____

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LIFE/AD&D (Dearborn National) **Benefit (Active Employees)**

□ **Core Plan (Employee Life/AD&D)** **$20,000**

(You MUST be enrolled in Medical coverage to receive this benefit. The box should only be checked if you are enrolled in Medical coverage)

BENEFICIARY INFORMATION for Life/AD&D

(for additional beneficiaries, attach a separate sheet)

Full Name of **Primary** Beneficiary (First, Middle, Last)	Relationship	Birth Date	Social Security Number
Address	City	State	Zip Code
Phone	Share %		

Full Name of **Contingent** Beneficiary (First, Middle, Last)	Relationship	Birth Date	Social Security Number
Address	City	State	Zip Code
Phone	Share %		

Full Name of **Contingent** Beneficiary (First, Middle, Last)	Relationship	Birth Date	Social Security Number
Address	City	State	Zip Code
Phone	Share %		

NAME_____

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HEALTH SAVINGS ACCOUNT (FIRST NATIONAL BANK OF OTTAWA)

I authorize **County of LaSalle** to initiate the following payroll deduction to contribute to my HSA. I understand that HSA contributions made through a Section 125 Plan will be made in accordance with the rules that apply to tax-free HSA contributions. In the event that my employer is using direct deposit to facilitate these contributions and makes a written request, I understand that my account number will be provided directly to my employer to facilitate this process.

Plan Year Election (01/01/19 – 12/31/19)

$ _____ (Employee's election will be divided by the number of payrolls for the **twelve-month period** above)

OR

□ I do not wish to elect employee payroll deductions toward the Health Savings Account.

IRS Maximum Contribution Limits for 2019 (Annual)

- Single Coverage: $3,500 or Family Coverage: $7,000
- Additional Catch-up Contribution (for those 55 and older): $1,000
- ***Total contributions into the HSA account for the 2019 calendar year may not exceed the limits above.***

I understand the eligibility requirements for contributions made to my Health Savings Account and state that I qualify to make contributions to this account.

_ I assume complete responsibility for:
  - Determining my eligibility for an HSA each year a contribution is made.
  - Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  - Any tax consequences of contributions (including rollover contributions) and distributions.

_ I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

_ I understand that upon enrollment I will be issued a DEBIT Card for HSA for use with my account. I understand that I am responsible for determining if an expense is an eligible medical expense and maintaining proper documentation for tax reporting and potential audit purposes.

_ I understand that I am establishing an HSA with **First National Bank of Ottawa,** in conjunction with Medical coverage through Blue Cross Blue Shield of Illinois. Funds are FDIC insured by **First National Bank of Ottawa** up to the legal limits allowed.

Signature: _____ Date: _____ / _____ / _____

YOUR APPROVAL OF BENEFIT SELECTIONS AND / OR WAIVERS

I have read the benefit information provided at Open Enrollment and understand my choices. I understand that these choices are effective for the entire plan year and cannot be altered unless I experience a change in family status, such as marriage, birth of child, divorce, disability or death; or loss of medical coverage under a spouse's plan.

I authorize the elections and / or waivers I have made as well as the payroll deductions required for those elections.

Signed by Employee_____

Date _____