



Benefit Election & Waiver Form - Public Works

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 City of Elmhurst 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 _____

**Change of Status is only applicable if you have experienced a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*

*** Please note that all eligible employees will be enrolled in employer sponsored Basic Life & AD&D.*

Client Name: <u>City of Elmhurst—Public Works</u>	Social Security #: _____
Employee Name: _____	Date of Hire: _____
Address: _____	Coverage Effective: _____
City, State, Zip: _____	Telephone #: _____
Date of Birth: _____ Gender: _____	Marital Status: _____

Vision Coverage Election I choose to waive vision coverage for myself and my dependents VSP

Vision Plan
30082920

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

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

Dependent Information—Vision Elections

Name	Social Security #	Birth Date	Gender	Relationship

Basic Life / AD&D Beneficiaries—\$25,000 benefit amount The Hartford

Primary Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				100%

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				100%

Voluntary Life / AD&D Coverage

The Hartford

- I choose to **elect** Voluntary Life coverage (indicate amount below)
 I choose to **waive** Voluntary Life coverage
 I choose to **elect** Voluntary AD&D coverage (must elect Voluntary Life & be equal to the Voluntary Life election amount)
 I choose to **waive** Voluntary AD&D coverage

MANDATORY: Please provide an email address if electing Voluntary Life/AD&D:

Type	Benefit Amount Offered	Guarantee Issue Amount	Voluntary Life Coverage Elected	Voluntary AD&D Coverage Elected*
Employee	Elect a maximum of \$500,000 in \$10,000 increments	\$250,000	\$	\$
Spouse	Elect a maximum of \$250,000 in \$5,000 increments	\$50,000	\$	\$
Child(ren)	Elect a maximum of \$10,000 in \$2,000 increments	\$10,000	\$	\$

*If electing Voluntary AD&D, the election must be equal to the Voluntary Life election.

NOTE: You must complete the **Evidence of Insurability** form if (1) You or your spouse previously waived or did not enroll when you first became eligible; (2) You have elected to purchase more than **\$250,000** for Employee Coverage; (3) You have elected to purchase more than **\$50,000** for Spouse Coverage; You must purchase coverage for yourself in order to purchase coverage for your spouse and/or child(ren). Late entrants and amounts over the Guarantee Issue are subject to underwriting approval. Coverage will begin on the first of the month following approval. In some instances, a physical exam by a doctor may be required. A spouse's maximum election cannot exceed 50% of the employee's election amount.

Voluntary Life/AD&D Rate Chart

Employee / Spouse Monthly Rates** per \$1,000 of Coverage		Employee / Spouse Monthly Rates** per \$1,000 of Coverage		Children Monthly Rates per \$1,000 of Coverage
Age <24	\$0.055	Age 50-54	\$0.275	Child(ren) Life \$0.200
Age 25-29	\$0.065	Age 55-59	\$0.455	
Age 30-34	\$0.080	Age 60-64	\$0.780	Child(ren) AD&D \$0.030
Age 35-39	\$0.095	Age 65-69	\$1.270	
Age 40-44	\$0.120	Age 70-74	\$2.300	
Age 45-49	\$0.180	Age 75+	\$3.720	
Employee/Spouse (all ages) AD&D \$0.030				

**Spouse Rate is based on employee age.

Voluntary Life/AD&D Beneficiaries

The Hartford

Primary Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				100%

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship	Benefit %
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				100%

Authorization and Signature

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. If you experience a qualifying life event, please contact your local Human Resources representative within 30 days of the life status change.

My signature below authorizes City of Elmhurst to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: _____