EIN: 36-6005866

GIN Benefit Election Retiree Form

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 any coverage, please check the box for waiving coverage. If a retiree voluntarily removes themselves or a family member from the retiree health, dental and/or vision insurance, the retiree and/or dependent will no longer be eligible to participate in the benefit moving forward.

If a retiree voluntarily removes themselves or a dependent from the City's retiree health, dental and/or vision insurance, the retiree and/or dependent will not be able to return to the insurance plan at any time and will no longer be eligible to participate in the benefit moving forward. Retirees and/or dependents may only participate in the City's insurance plan(s) as a retiree if they are enrolled in the City's insurance plan(s) at the time of retirement.

☐ **Open Enrollment**

Client Name:	City of Elmhurst	Social Security #:	
Retiree Name:		Date of Hire:	
Address:		Coverage Effective:	
City, State, Zip:		Telephone #:	
Date of Birth:	Gender:	Marital Status:	

Medical Coverage

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

	HMO BA B05096	PPO 300 w/ BCO 305948	PPO HDHP 230713
Retiree Only	☐	☐	☐
Retiree + Spouse	☐	☐	☐
Retiree + Child(ren)	☐	☐	☐
Family	☐	☐	☐

Note: Fill out dependent information below if you elect a tier other then 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**

	CORE Plan 230716	Low Plan 230715	High Plan 230717
Retiree Only	☐	☐	☐
Retiree + Spouse	☐	☐	☐
Retiree + Child(ren)	☐	☐	☐
Family	☐	☐	☐

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

Vision Coverage Election

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

	Vision Plan 30082920
Retiree Only	☐
Retiree + Spouse	☐
Retiree + Child(ren)	☐
Family	☐

Note: Fill out dependent information below if you elect a tier other then 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

EIN: 36-6005866

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

Authorization and Signature

Your next opportunity to make changes will be during the next open enrollment period.

Name: _____ Signature: _____ Date: _____