ILLINOIS SCHOOL
Insurance Network

Enrollment / Change Checklist

TO BE COMPLETED BY EMPLOYER

Employee Name:	
Reason for Enrollment / Change:	☐ Retirement ☐ Other | Describe:_____ ☐ Open Enrollment
Coverage Elected	
Medical Insurance BCBS of IL	☐ Enrolled in PPO ☐ Enrolled in HMO ☐ Confirm Medical Group # provided on application ☐ Waived Medical
Dental Insurance BCBS of IL	☐ Enrolled in Dental ☐ Waived Dental
Vision Insurance VSP	☐ Enrolled in Vision ☐ Waived Vision

Employee Salary:_____

Benefit Class:_____

Employees: Please submit along with all other required forms to your HR Department contact.

HR Department: Please submit along with all other required forms to:

Illinois School Insurance Network

Email: mwil.isinadministration@marshmma.com

EIN: 36-6004402

Benefit Election & Waiver Form

Lemont Township High School District 210: Retiree

Please complete the following election form for your benefits. Select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered, and are therefore waiving all coverage, please check the box for waiving coverage under each benefit. The top portion of this form must be completed in its entirety. Form is not valid unless signed.

☐ **Open Enrollment** ☐ **Initial Retirement**

In order to continue retiree coverage past age 65, the retiree *must* contact the district.

REQUIRED INFORMATION

District Name: Lemont Township High School District 210
Retiree Name: _____
Address: _____
City, State, Zip: _____
Date of Birth: / / Gender: ☐ M ☐ F
Email: _____

Social Security #: — —
Date of Retirement: / /
Coverage Effective: / /
Telephone #: — —
Marital Status: _____

Medical Coverage Election

☐ I choose to waive medical coverage for the plan year. **BCBS of Illinois**

	BA HMO** Plan 2 B03881	PPO 165607
Retiree Only	☐	☐
Retiree + 1*	☐	☐
Family*	☐	☐

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

****If you select HMO, you must provide a Medical Group # and PCP Information on the next page.**

Dental Coverage Election

☐ I choose to waive dental coverage for the plan year. **BCBS of Illinois**

	Dental DPPO 270728
Retiree Only	☐
Retiree + 1*	☐
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 the plan year. **VSP**

	Vision Plan 175 12019596
Retiree Only	☐
Retiree + 1*	☐
Family*	☐

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

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					

Medical PCP Information

THIS INFORMATION IS REQUIRED IF ENROLLING IN MEDICAL HMO PLAN

Name of Enrolled	Medical PCP Name	9-Digit PCP ID Number	3-Digit Medical Group/ IPA Number

Authorization and Signature

Complete this form in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during the next open enrollment period.

Name: _____ Signature: _____ Date: ____/____/____