



## Enrollment / Change Checklist

**TO BE COMPLETED BY EMPLOYER**

Employee Name:		
Reason for Enrollment / Change:	<input type="checkbox"/> New Hire <input type="checkbox"/> Birth	<input type="checkbox"/> Marriage
	<input type="checkbox"/> Job Status Change <input type="checkbox"/> Lost Other Coverage <input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Other   Describe: _____
<b>Coverage Elected</b>		
<b>Medical Insurance</b> BCBS of IL	<input type="checkbox"/> Enrolled in PPO/HDHP <input type="checkbox"/> Waived Medical	<input type="checkbox"/> Enrolled in HMO <input type="checkbox"/> Confirm Medical Group # provided on application
<b>Dental Insurance</b> BCBS of IL	<input type="checkbox"/> Enrolled in Dental <input type="checkbox"/> Waived Dental	
<b>Vision Insurance</b> VSP	<input type="checkbox"/> Enrolled in Vision <input type="checkbox"/> Waived Vision	
<b>Life/AD&amp;D Insurance</b> BCBS of IL (Dearborn)  Employee Salary: _____  Benefit Class: _____	<input type="checkbox"/> Basic Life/AD&D   Benefit Amount: \$ _____ <input type="checkbox"/> Enrolled in Voluntary Life/AD&D   Employee Amount: \$ _____ <input type="checkbox"/> Evidence of Insurability (EOI) Needed   Spouse Amount: \$ _____   Child(ren) Amount: \$ _____  <input type="checkbox"/> Waived Voluntary Life/AD&D	

**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](mailto:mwil.isinadministration@marshmma.com)**



# Benefit Election & Waiver Form

EIN: 36-2829561

SOWIC: ALL ELIGIBLE EMPLOYEES

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       New Hire       Qualifying Life Event\* (Please Describe) \_\_\_\_\_

\*Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.

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

REQUIRED INFORMATION

District Name:	SOWIC	Social Security #:	—	—
Employee Name:	_____	Date of Hire:	/	/
Address:	_____	Coverage Effective:	/	/
City, State, Zip:	_____	Telephone #:	—	—
Date of Birth:	/ /	Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F
Email:	_____	Marital Status:	_____	_____

## Medical Coverage Election I choose to waive medical coverage for the plan year. BCBS of Illinois

	BA HMO** Plan 3 B14332	BA HMO** Plan 4 B01776	PPO 165622	HDHP w/ HSA 165602	
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Note: Fill out dependent information below if you elect a tier other than Employee Only.  **If you select HMO, you must provide a Medical Group # and PCP Information on the next page.
Employee + 1*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Dental Coverage Election I choose to waive dental coverage for the plan year. BCBS of Illinois

	DPPO 1000 270728	
Employee Only	<input type="checkbox"/>	*Note: Fill out dependent information below if you elect a tier other than Employee Only.
Employee + 1*	<input type="checkbox"/>	
Family*	<input type="checkbox"/>	

## Vision Coverage Election I choose to waive vision coverage for the plan year. VSP

	Vision Plan 175 12019596	
Employee Only	<input type="checkbox"/>	*Note: Fill out dependent information below if you elect a tier other than Employee Only.
Employee + 1*	<input type="checkbox"/>	
Family*	<input type="checkbox"/>	

## 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

## Basic Life / AD&D Beneficiaries

BCBS of Illinois

SOWIC provides a **\$30,000** Basic Life/AD&D benefit. Please list the beneficiaries you wish to have on file.

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

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

## Voluntary Life / AD&D Coverage (employee is responsible for the full cost of premium)

BCBS of Illinois

I choose to **elect** Voluntary Life/ AD&D coverage (indicate amount below)       I choose to **waive** Voluntary Life /AD&D coverage

Type	Benefit Amount Offered	Guarantee Issue Amount	Life / AD&D Coverage Elected	Life Coverage Elected
Employee	Elect up to \$100,000 in \$25,000 increments, not to exceed 5x annual earnings	\$100,000, Not to exceed 3x earnings	\$	
Spouse	Elect up to \$50,000 in \$10,000 increments, not to exceed 50% of employee election	\$20,000		\$
Child(ren)	15 Days - 6 Months: \$500; 6 months to age 26: \$5,000 Dependent child(ren) rate covers all eligible children	\$5,000		\$

**Monthly Rate Table** - Please select your age band as of the benefit effective date. Spouse rate is based on spouse age.

Age Band	Employee Rate per \$25,000	Spouse Rate per \$10,000	Age Band	Employee Rate per \$25,000	Spouse Rate per \$10,000	Age Band	Employee Rate per \$25,000	Spouse Rate per \$10,000
<25	<input type="checkbox"/> \$2.05	<input type="checkbox"/> \$0.62	40-44	<input type="checkbox"/> \$3.58	<input type="checkbox"/> \$1.23	60-64	<input type="checkbox"/> \$20.88	<input type="checkbox"/> \$8.15
25-29	<input type="checkbox"/> \$2.35	<input type="checkbox"/> \$0.74	45-49	<input type="checkbox"/> \$5.13	<input type="checkbox"/> \$1.85	65-69	<input type="checkbox"/> \$39.73	<input type="checkbox"/> \$15.69
30-34	<input type="checkbox"/> \$2.98	<input type="checkbox"/> \$0.99	50-54	<input type="checkbox"/> \$7.60	<input type="checkbox"/> \$2.84	70-74	<input type="checkbox"/> \$64.10	N/A
35-39	<input type="checkbox"/> \$3.28	<input type="checkbox"/> \$1.11	55-59	<input type="checkbox"/> \$13.78	<input type="checkbox"/> \$5.31	75+	<input type="checkbox"/> \$64.10	N/A
Child(ren) Rate per \$5,000				<input type="checkbox"/> \$0.63				

**NOTE:** You must complete the **Evidence of Insurability** form if (1) You previously waived or did not enroll when you first became eligible; (2) You have elected to purchase more than **the Guarantee Issue** for Employee Coverage; (3) You have elected to purchase more than **\$20,000** for Spouse Coverage; (4) you have elected to purchase any amount of coverage for your spouse and/or child(ren) that previously waived or did not enroll when you first became eligible. 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. The dependent child(ren) rate covers all eligible children.

As of 01.01.2026

## Voluntary Life / AD&D Beneficiaries

BCBS of Illinois

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

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

## Health Savings Account (HSA) Election

I choose to **contribute** to an HSA (indicate amount below)

I choose **not to contribute** to an HSA

If you have elected the High Deductible Health Plan (HDHP), you may open a Health Savings Account. See your HR representative with questions.

	Employee Only	Family (Employee + 1 or more)
Maximum IRS Annual HSA Contributions 2026	\$4,400	\$8,750
"Catch-Up" Contributions (individuals aged 55 and older)	Additional \$1,000	Additional \$1,000
Your <b>Monthly</b> Contribution:	\$_____ per month	\$_____ per month

\*Once enrolled in Medicare, you are no longer eligible to contribute to your HSA account.

## Authorization and Signature

Every employee is required to 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, 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 Benefits Department within 30 days of the life status change.

**My signature below authorizes SOWIC to deduct insurance premiums on a pre-tax basis.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_