glantz design

Benefits Enrollment Form
for the 2019 - 2020 Plan Year

NOTE: See Employee Contribution Worksheet for rates.

SECTION 1 - Employee Information (all information is required)

First Name:	**Social Security Number:**
Last Name:	**Gender:** Male ❑ Female ❑
Birth Date:	**Estimated Annual Earnings OR Hourly Rate & Avg Hrs. a week** (MUST BE FILLED OUT)
Home address:	**Hire Date:**
City, State, Zip:	**Enrollment Effective Date:** New Hire Waiting Period is 1st day of the month following date of employment

SECTION 2 - Type of Enrollment Request

New Hire ❑ Benefit Waiting Period: 1st day of the month following date of employment

Open Enrollment ❑ Only effective April 1st

Qualifying Event ❑ Please indicate reason : _____
(i.e. marriage, birth of a child, spousal loss of coverage, etc.)

SECTION 3 - Benefit Elections

Medical
BlueCross BlueShield of Illinois

❑ Changes
❑ No Changes

Choose One: *(Pick your plan)*	**HMO Platinum** (P506PSN)	**HMO Gold** (G532PSN)	**HSA** (G533PPO)	**PPO** (S532PPO)	**HMO Silver** (S530PSN)
Enroll ❑ / WAIVE ❑ — Single	❑	❑	❑	❑	❑
You + Spouse	❑	❑	❑	❑	❑
You + Child(ren)	❑	❑	❑	❑	❑
Family	❑	❑	❑	❑	❑

If HMO, indicate:
HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____
HMO PCP Name: _____ PCP ID - 9-Digit#: _____
Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____
Current Patient? Yes ❑ No ❑

Life/AD&D
Principal

❑ Changes
❑ No Changes

Glantz Design provides eligible employees an employer paid Life & ADD Insurance Benefit. See the plan summary for more details.

Primary Beneficiary Name: _____ Relationship: _____ Percent: _____
Name: _____ Relationship: _____ Percent: _____
Secondary Beneficiary Name: _____ Relationship: _____ Percent: _____
Name: _____ Relationship: _____ Percent: _____

STD
Principal

Glantz Design provides an employer-paid Short Term Disability (STD) Insurance Benefit to all eligible employees. See the plan summary for more details.

_X_ Elect (automatically enrolled)

SECTION 4 - Dependent Elections

Dep #1

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

Dep #2

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

Dep #3

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

Dep #4

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

Dep #4

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

Dep #5

❑ Enroll
❑ Cancel
❑ Medical
❑ Dental

Dependent Name: _____ **Relationship:** _____ **Social Sec. No.:** _____

Birth Date: _____ **Gender:** Female ❑ Male ❑

If HMO, indicate: HMO Medical Group Name: _____ Medical Group ID - 3-Digit#: _____

HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Women's Health PCP Name: _____ PCP ID - 9-Digit#: _____

→ Current Patient? Yes ❑ No ❑

SECTION 5 - Section 125 approval and Signatures

I hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) state that I became an employee on the date stated above, and do currently work at least 40 hours per week; (3) understand I cannot change any of these elections unless I have an IRS-defined qualifying event.
I authorize my employer to make these deductions from my paycheck (on a pre-tax basis, where applicable).
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I have reviewed the statements on this application and they are true and complete.

EMPLOYEE SIGNATURE **DATE**

HR NOTE: Please verify application is correctly & entirely completed. Then scan/email (preferred) or fax (312-278-0214) all forms to Stumm Insurance LLC.
Once processed by Stumm, we will send a confirmation email. Then going forward, please review subsequent carrier billing for accuracy.