glantz design

Benefits Enrollment Form

Benefits Enrollment Form for Plan Year 4/1/2024 - 3/31/2025

SECTION 1 - Employee Information (all information is required)

Name (Last, First):	**Gender:** Male ❑ Female ❑
Social Security Number:	**Birth Date:**
Home Street Address:	**City, State, Zip:**
Phone:	**Email:**

Are you or any of your dependents:

1) Eligible for Medicare? Yes ❑ No ❑

2) Disabled and/or Not Actively at Work? Yes ❑ No ❑

**(If you answer yes to any question, HR may have to follow-up for additional questions)*

To be completed by HR:

Hire Date: **Effective Date:** **Job Title:** **Salary:**

SECTION 2 - ENROLLMENT REASON

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: _____ (Note: Enrollment form must be submitted within 30 days of qualifying event.)
(i.e. marriage, birth of a child, spousal loss of coverage, etc.)

SECTION 3 - Benefit Elections *All deduction amounts shown below are Per Paycheck (24 periods)

Medical

BlueCross BlueShield of Illinois

Choose One:

Enroll ❑ → Please choose your plan:

Waive ❑ I am covered on my spouse/parent's plan

Waive ❑ I have individual coverage

Waive ❑ I have Medicare or other Government program

Waive ❑ I have no coverage

	HMO Platinum (P506PSN)	HMO Gold (G532PSN)	HMO Silver (S530PSN)
Single	❑	❑	❑
You + Spouse	❑	❑	❑
You + Child(ren)	❑	❑	❑
Family	❑	❑	❑

New - Replaces S532PPO

	Options PPO (G507OPT)	HSA (G533PPO)	OPTIONS HSA (G5K1OPT)
Single	❑	❑	❑
You + Spouse	❑	❑	❑
You + Child(ren)	❑	❑	❑
Family	❑	❑	❑

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

**Required only if enrolling in HMO for the 1st time.* HMO PCP Name: _____ PCP ID - 9-Digit#: _____

Current Patient? Yes ❑ No ❑ **Please note, if you do not identify a Primary Care Physician, one will be assigned to you.*

Dental

Principal

Choose One:

Enroll ❑ → Please choose your plan:

Waive ❑

	Per Pay (24)
Single ❑	$23.37
You + Spouse ❑	$43.26
You + Child(ren) ❑	$51.24
Family ❑	$74.46

Vision

Principal

Choose One:

Enroll ❑ → Please choose your plan:

Waive ❑

	Vision PPO (24)
Single ❑	$1.77
You + Spouse ❑	$5.17
You + Child(ren) ❑	$5.66
Family ❑	$9.83

Basic Life/AD&D

Principal

The company provides to all eligible employees a Life/AD&D Benefit at no cost. You are automatically enrolled.

Primary Beneficiary Name: _____ Relationship: _____ Percent: _____

Name: _____ Relationship: _____ Percent: _____

Contingent Beneficiary Name: _____ Relationship: _____ Percent: _____

Name: _____ Relationship: _____ Percent: _____

Short-Term Disability

Principal

Glantz Design provides to all eligible employees a Short Term Disability (STD) at no cost. You are automatically enrolled.

X Elect (automatically enrolled)

SECTION 4 - Dependent Details (Actual Enrollment is made in Section 3)

Spouse

Name: _____ **Social Sec. No.:** _____ **DOB:** _____ **Gender:** _____

	Enroll	*Waive*
Medical	❑	❑
Dental	❑	❑
Vision	❑	❑

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

Child #1

Name: _____ **Social Sec. No.:** _____ **DOB:** _____ **Gender:** _____

	Enroll	*Waive*
Medical	❑	❑
Dental	❑	❑
Vision	❑	❑

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

Child #2

Name: _____ **Social Sec. No.:** _____ **DOB:** _____ **Gender:** _____

	Enroll	*Waive*
Medical	❑	❑
Dental	❑	❑
Vision	❑	❑

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

Child #3

Name: _____ **Social Sec. No.:** _____ **DOB:** _____ **Gender:** _____

	Enroll	*Waive*
Medical	❑	❑
Dental	❑	❑
Vision	❑	❑

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

Child #4

Name: _____ **Social Sec. No.:** _____ **DOB:** _____ **Gender:** _____

	Enroll	*Waive*
Medical	❑	❑
Dental	❑	❑
Vision	❑	❑

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

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 30 hours per week; (3) understand I cannot change any of these elections unless I have an IRS-defined qualifying event. Any falsification of company records may involve disciplinary action, up to and including termination of employment.

I authorize my employer to make these deductions from my paycheck and on a pre-tax basis (unless otherwise noted).

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**

NOTE: Please refer to the Certificate of Coverage(s) for all eligibility, exclusions, coverage levels for all benefit plans listed.