glantz design

Benefits Enrollment Form
for the 2017 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:	**Occupation:**
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 - Bronze**	**HMO - Gold**	**HMO - Platinum**	**PPO**	**HSA Plan**
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 ❑

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 #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 REPRESENTATIVE SIGNATURE **DATE**

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.

Glantz **Name:** _____

2017 - 2018 BlueCross BlueShield Medical Plan

Employee Contributions Worksheet **Date:** _____

Step 1: Choose Your Plan

Benefit Provision	HMO Platinum	PPO	HSA	HMO Gold	HMO Bronze
Indicate with an "X"					
Metallic Level	Platinum	Silver	Platinum	Gold	Bronze
Network	BluePrecision HMO	PPO	PPO	BluePrecision HMO	BluePrecision HMO
Deductible Per Person (In/Out)	$0 / na	$2,700 / $5,400	$2,600 / $5,200	$2,500 / na	$6,800 / na
Family Ded. Max (In/Out)	$0 / na	$8,100 / $16,200	$7,800 / $15,600	$5,000 / na	$14,000 / na
Office Visit / Specialist Copays	$10 / $45	$35 / $65	Ded. & Coins.	$30 / $50	$50 / $100
ER / IP / OP (In)	$300/150/100	$500/250/200	Ded. & Coins.	$400/200/150 (+20%)	$1,000/750/500 (+50%)
Your Coinsurance (In/Out)	0% / na	20% / 40%	0% / 0%	20% / na	50% / na
OOP Max Per Person (In/Out)	$1,500 / na	$6,700 / $13,400	$2,600 / $5,200	$5,000 / na	$7,150 / na
Family OOP Max (In/Out)	$4,500 / na	$14,000 / $28,000	$7,800 / $15,600	$12,700 / na	$14,000 / na
Your Rx Costs	$0/10/50/100/150	$0/10/50/100/150	Ded. & Coins.	$0/10/50/100/150	0%/20%/20%/30%/40%

Note: For more details on plan provision, please refer to your Summary of Benefits & Coverage (SBC). If differences, default to SBC.

Member Age as of Renewal (or Start Date)	HMO Platinum		PPO		HSA		HMO Gold		HMO Bronze	
	Employee	Dependent	Employee	Dependent	Employee	Dependent	Employee	Dependent	Employee	Dependent
Age 0 - 20	$63.22	$100.24	$82.26	$119.28	$94.46	$131.48	$52.04	$89.06	$24.68	$61.70
21	$99.56	$157.86	$129.54	$187.84	$148.75	$207.05	$81.95	$140.25	$38.87	$97.17
22	$99.56	$157.86	$129.54	$187.84	$148.75	$207.05	$81.95	$140.25	$38.87	$97.17
23	$99.56	$157.86	$129.54	$187.84	$148.75	$207.05	$81.95	$140.25	$38.87	$97.17
24	$99.56	$157.86	$129.54	$187.84	$148.75	$207.05	$81.95	$140.25	$38.87	$97.17
25	$99.95	$158.49	$130.06	$188.59	$149.34	$207.88	$82.27	$140.81	$39.02	$97.56
26	$101.95	$161.65	$132.65	$192.35	$152.32	$212.02	$83.91	$143.61	$39.80	$99.50
27	$104.33	$165.43	$135.76	$196.86	$155.89	$216.99	$85.88	$146.98	$40.73	$101.83
28	$108.22	$171.59	$140.81	$204.18	$161.69	$225.06	$89.07	$152.45	$42.25	$105.62
29	$111.40	$176.64	$144.96	$210.20	$166.45	$231.69	$91.70	$156.94	$43.49	$108.73
30	$113.00	$179.17	$147.03	$213.20	$168.83	$235.00	$93.01	$159.18	$44.11	$110.28
31	$115.39	$182.96	$150.14	$217.71	$172.40	$239.97	$94.98	$162.55	$45.05	$112.62
32	$117.77	$186.74	$153.25	$222.22	$175.97	$244.94	$96.94	$165.91	$45.98	$114.95
33	$119.27	$189.11	$155.19	$225.03	$178.20	$248.04	$98.17	$168.02	$46.56	$116.41
34	$120.86	$191.64	$157.26	$228.04	$180.58	$251.36	$99.48	$170.26	$47.18	$117.96
35	$121.66	$192.90	$158.30	$229.54	$181.77	$253.01	$100.14	$171.38	$47.49	$118.74
36	$122.45	$194.16	$159.34	$231.05	$182.96	$254.67	$100.79	$172.50	$47.81	$119.52
37	$123.25	$195.43	$160.37	$232.55	$184.15	$256.32	$101.45	$173.63	$48.12	$120.29
38	$124.04	$196.69	$161.41	$234.05	$185.34	$257.98	$102.10	$174.75	$48.43	$121.07
39	$125.64	$199.22	$163.48	$237.06	$187.72	$261.29	$103.42	$176.99	$49.05	$122.62
40	$127.24	$201.74	$165.56	$240.06	$190.10	$264.61	$104.73	$179.24	$49.67	$124.18
41	$129.62	$205.53	$168.66	$244.57	$193.67	$269.58	$106.69	$182.60	$50.60	$126.51
42	$131.91	$209.16	$171.64	$248.89	$197.09	$274.34	$108.58	$185.83	$51.50	$128.75
43	$135.10	$214.21	$175.79	$254.90	$201.85	$280.96	$111.20	$190.31	$52.74	$131.86
44	$139.08	$220.53	$180.97	$262.41	$207.80	$289.24	$114.48	$195.92	$54.30	$135.74
45	$143.76	$227.95	$187.06	$271.24	$214.79	$298.98	$118.33	$202.52	$56.12	$140.31
46	$149.34	$236.79	$194.31	$281.76	$223.12	$310.57	$122.92	$210.37	$58.30	$145.75
47	$155.60	$246.73	$202.47	$293.60	$232.49	$323.61	$128.08	$219.21	$60.75	$151.87
48	$162.78	$258.10	$211.80	$307.12	$243.20	$338.52	$133.98	$229.30	$63.55	$158.87
49	$169.84	$269.30	$221.00	$320.46	$253.76	$353.22	$139.80	$239.26	$66.31	$165.77
50	$177.81	$281.93	$231.36	$335.48	$265.66	$369.78	$146.36	$250.48	$69.41	$173.54
51	$185.67	$294.40	$241.59	$350.32	$277.41	$386.14	$152.83	$261.56	$72.49	$181.22
52	$194.34	$308.14	$252.87	$366.67	$290.35	$404.15	$159.96	$273.76	$75.87	$189.67
53	$203.10	$322.03	$264.27	$383.20	$303.44	$422.37	$167.17	$286.10	$79.29	$198.22
54	$212.55	$337.02	$276.57	$401.04	$317.57	$442.04	$174.96	$299.43	$82.98	$207.45
55	$222.01	$352.02	$288.88	$418.89	$331.70	$461.71	$182.74	$312.75	$86.67	$216.68
56	$232.26	$368.28	$302.22	$438.23	$347.02	$483.04	$191.18	$327.19	$90.67	$226.69
57	$242.62	$384.70	$315.69	$457.77	$362.50	$504.57	$199.70	$341.78	$94.72	$236.79
58	$253.67	$402.22	$330.07	$478.62	$379.01	$527.55	$208.80	$357.35	$99.03	$247.58
59	$259.14	$410.90	$337.20	$488.95	$387.19	$538.94	$213.31	$365.06	$101.17	$252.92
60	$270.20	$428.42	$351.58	$509.80	$403.70	$561.92	$222.40	$380.63	$105.48	$263.71
61	$279.75	$443.58	$364.01	$527.83	$417.97	$581.80	$230.27	$394.09	$109.21	$273.04
62	$286.02	$453.52	$372.17	$539.67	$427.35	$594.84	$235.43	$402.93	$111.66	$279.16
63	$293.89	$465.99	$382.41	$554.51	$439.10	$611.20	$241.91	$414.01	$114.73	$286.83
64	$298.67	$473.57	$388.62	$563.52	$446.24	$621.14	$245.84	$420.74	$116.60	$291.50
65 or older	$298.67	$473.57	$388.62	$563.52	$446.24	$621.14	$245.84	$420.74	$116.60	$291.50

Step 2: Calculate Your Costs:

All Rates Based on 24 Paychecks Per Year

		# Enrolled		Rate (from table)		Per Paycheck Premium
A	You	1	x	$	=	$
B	Your Spouse		x	$	=	$
C	Adult Child (Age 21-25)		x	$	=	$
D	Adult Child (Age 21-25)		x	$	=	$
E	Adult Child (Age 21-25)		x	$	=	$
F	Children Age 0-20	(Only charged for max of 3)	x	$	=	$
G	TOTAL NUMBER ENROLLED (A-F):			SUB-TOTAL:		$
	TOTAL PER-PAYCHECK PREMIUM DEDUCTION:					$