BENEFITS ENROLLMENT/CHANGE FORM • COOK COUNTY EMPLOYEE HEALTH BENEFITS

County Building • Employee Benefits Division • 161 N. Clark Street, Suite 2400B • Chicago, IL 60601
312-603-6385 (phone) • 866-729-3040 (fax) • risk.mgmt@cookcountyil.gov (email)

COBRA

INSTRUCTIONS: Complete and sign this form. Make a copy for your records. Return to Employee Benefits Division. Print clearly using a pen.

Please review the plan options and requirements at cookcountyrisk.com. All family members must be covered under the same plans under the same employee enrollment. Benefits end on the last day of the month in which the employee is employed. COBRA must begin on the first day of the month following the end of active coverage. You must complete and return this form within 60 days of your last day of coverage.

EMPLOYEE INFORMATION

Social Security #__________ Last Name__________ First Name__________ MI____

Address__________ Apt. #____ City/State__________ ZIP Code____

Home/Cell Phone__________ Work Phone__________ Employee ID #__________ Dept. #____

Birth Date________ Employment Date ________ Married: ☐ Yes ☐ No Marriage Date________ Gender: ☐ Male ☐ Female

Union: ☐ Yes ☐ No If yes, Union Name and Number__________

Employee Email __________

PLAN ELECTION

Check the box by the plan(s) of your choice. If you are a new employee and a member of a union, you must choose the medical HMO and dental HMO for the first year of employment.

Medical	Dental	Vision
☐ Blue Advantage HMO – Medical Group # ________ (employee)	☐ Dental HMO	☐ Vision Plan
☐ Blue Cross PPO	☐ Dental PPO	

If you select the HMO, you must select a primary doctor/dentist. Medical HMO members will not receive an ID card until BCBS receives your medical group number.

DEPENDENT ENROLLMENT

Last Name	First Name	Relationship to You	Gender	Birth Date	Social Security #	HMO Medical Group #
			M / F			
			M / F			
			M / F			
			M / F			

CHANGE INFORMATION

To be completed by employee. Check items as appropriate.

TYPE OF CHANGE

☐ New Employee

☐ Reinstatement

☐ Add Dependent Date of event ________

☐ Delete Dependent Date of event ________

☐ Terminate Insurance

COBRA INFORMATION ISSUED?

☐ Yes ☐ No Date ________

EFFECTIVE DATE__________

Comments (Employee Benefits Staff Only)__________

____

____

Initials	Date

CERTIFICATION

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I authorize the deduction of the applicable rate necessary for payment of my health coverage and agree to pay all applicable out-of-pocket expenses including deductible, coinsurance and copayments. I authorize my doctors, hospital or other provider of medical services to make available to the claims administrator any and all medical records pertaining to myself and my dependents, if any. I also release to the claims administrator any information regarding the medical treatment and benefits for myself and any dependents for the purpose of reviewing medical treatment, validating and determining benefits, as well as for plan administration.

Employee Signature__________ Date Signed__________

60 Days