City of Rock Island
BENEFITS ENROLLMENT FORM
2025 Medical, Dental & Vision

Employee Name (Last, First, MI): _____DOB: _____ SS#_____
Street/Mailing Address: _____ City/State/Zip: _____
Home Phone: _____ Email: _____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced Date of Employment: _____

Note: All premiums listed below are per pay period (26 per year). Effective Date: _____

BCBS of Illinois Medical PPO Plan Coverage Options:

Medical Plan: ☐ Employee ($97.52) ☐ Employee/Spouse ($195.03) ☐ Employee/Child ($185.28) ☐ Family ($272.07)

I ***decline*** coverage for: ☐ Myself ☐ My Spouse ☐ My Dependents

Reason for declining is: _____

Delta Dental of Illinois Coverage Options:

Low Plan ($1000 Maximum) Premiums per pay period: ☐ Employee ($13.26) ☐ Employee/Spouse ($26.51) ☐ Employee/Child ($32.74) ☐ Family ($52.12)

High Plan ($2000 Maximum) Premiums per pay period: ☐ Employee (15.28) ☐ Employee/Spouse ($30.56) ☐ Employee/Child ($40.28) ☐ Family ($61.41)

I ***decline*** coverage for: ☐ Myself ☐ My Spouse ☐ My Dependents

Reason for declining is: _____

Avesis Vision Coverage Options:

Vision Plan: ☐ Employee ($4.25) ☐ Employee/Spouse ($8.15) ☐ Employee/Child ($8.88) ☐ Family ($11.44)

I ***decline*** coverage for: ☐ Myself ☐ My Spouse ☐ My Dependents

Reason for declining is: _____

Please complete for all covered dependents, including your spouse. (If you need additional room, please attach additional paper.)

Dependent Name: (First, MI, Last)	Gender (circle)	Relationship to You	Date of Birth (MM/DD/YYYY)	Social Security Number	Does person have other health coverage including Medicare? If so, List insurance company name and policy no.
	M F				
	M F				
	M F				
	M F				

Attach copies of legal court custody decrees or Qualified Medical Child Support Order.

Is any Dependent or Spouse disabled? ☐ No ☐ Yes
Name of Disabled Dependent: _____ Type of Disability/Date it began: _____

Spouse Information (Complete only if requesting coverage for Spouse.) Is spouse employed? ☐ Yes ☐ No
Spouse's Employer (Company name): _____ Employer Address (City/State/Zip): _____

Does your Spouse have group medical insurance through his/he employer? ☐ Yes ☐ No If yes, please state name of Carrier & Effective Date: _____ Type of coverage: ☐ Single ☐ Family

Note: This information is needed solely for coordination of benefits for the insurance plans.
Important information: Please read and sign below.

***Special Enrollment Provision (Medical/Dental/Vision)**

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about very important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" without being considered a late enrollee if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later loses that other coverage for certain qualifying reasons. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. **SPECIAL ENROLLMENT PROVISIONS**

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or move out of the prior plan's HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

IMPORTANT: THIS FORM MUST BE COMPLETED OR THE SPECIAL ENROLLMENT PERIOD WILL NOT APPLY.

ASSIGNMENT AND AUTHORIZATION

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE TO OR BY BCBS OF ILLINOIS, TO OR BY DELTA DENTAL OF ILLINOIS, TO OR BY AVESIS, OF ANY HOSPITAL, MENDICAL, OR OTHER INSURANCE INFORMATION, CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNTS AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM, MY EARNINGS.

I HAVE READ ALL OF THE INFORMATION OUTLINED ABOVE AND COMPLETED THE ABOVE TO THE BEST OF MY KNOWLEDGE & ABILITIES.

Employee Name: _____ Date: _____

City of Rock Island

2025 Insurance Premiums Pre-Tax Enrollment Form

Employee Name: _____
(Please Print)

BCBS of Illinois Medical PPO Plan

Premiums per period (26 per year):

_____ Employee	$97.52
_____ Employee/Spouse	$195.03
_____ Employee/Child	$185.28
_____ Family	$272.07
_____ Waive Medical Coverage	

Delta Dental of Illinois Plan

Low Plan ($1000 Maximum) Premiums per pay period:

_____ Employee	$13.26
_____ Employee/Spouse	$26.51
_____ Employee/Child	$32.74
_____ Family	$52.12
_____ Waive Dental Coverage	

High Plan ($2000 Maximum) Premiums per pay period:

_____ Employee	$15.28
_____ Employee/Spouse	$30.56
_____ Employee/Child	$40.28
_____ Family	$61.41
_____ Waive Dental Coverage	

Avesis Vision Plan

Premiums per period (26 per year):

_____ Employee	$4.25
_____ Employee/Spouse	$8.15
_____ Employee/Child	$8.88
_____ Family	$11.44
_____ Waive Vision Coverage	

Note: These premiums will be taken out as pre-tax deductions on your paycheck. If you would like the deductions taken out on a **post-tax basis**, please **check here**: _____

Signature: _____ Date: _____