2026 Enrollment Form
ACTIVE Employees

CONFIDENTIAL INFORMATION

THE VILLAGE OF OAK LAWN

SECTION 1 – Personal Information & Elections

Employee Information

Last Name, First Name, Middle Initial	Gender	Social Security Number	Email Address (please complete)
Address		Preferred Phone Number	Date of Birth
City	State	Zip Code	Date of Hire

Plan	Plans Effective January 1, 2026	Plan Year 2026 Benefit Elections
Medical &, Prescription Drugs	**Waive Coverage**	☐ I am waiving my Medical Coverage for 2026 (Please complete Medical Buyout Form)
	BCBS IL Blue Advantage HMO (Base Plan)	**HMO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family **Employee PCP and Medical IPA Number:** _____
	BCBS IL HMO Illinois	**HMO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family **Employee PCP and Medical IPA Number:** _____
	BCBS IL BCO PPO	**PPO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Dental	**Delta Dental**	**Dental PPO** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Waive Coverage
Vision	**Eye Med Vision**	**Vision PPO** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Waive Coverage

SECTION 2 – Dependent Enrollment (Medical, Dental and Vision)

I elect to enroll my dependents listed below. Dependent shall mean any of the following: (a) The employee's lawful spouse recognized by the federal government; or (b) eligible employee's natural or adopted children including children placed with the employee for the purpose of adoption or legal guardianship; or (c) step children, living in a parent-child relationship with the employee, who; is a dependent of the employee, resides in the same country as the covered employee, and is under 26 years old or (d) is mentally or physically disabled in accordance with the handicapped children's provision.

Dependent Name	Gender	Date of Birth	Relationship	Social Security # (Required if adding dependent to coverage)	Primary Care Physician (PCP #) & Medical Group IPA # (Required if electing HMO Plan for dependents)

SECTION 3 – Beneficiary Designation (Basic Life & AD&D, and Voluntary Life/AD&D if applicable) **Beneficiary information is required even if waiving other benefits.**

Primary Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Phone Number	Address (Street, city, state, zip)	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated
In the event said primary beneficiary (ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

Total (= to 100%)

Contingent Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Phone Number	Address (Street, city, state, zip)	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Policy.

Total (= to 100%)

SECTION 4 – Acknowledgement and Authorization

1. If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth adoption, or placement for adoption.
2. I agree that my enrolled family and I shall abide by the provision of coverage in the service agreement of the Plan under which we are enrolled. The Plan document will determine the rights and responsibilities of member(s) and will govern in the event of a conflict with any benefits comparison or summary.
3. I hereby authorize any provider, insurance company, or organization to release any information regarding treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with these Plans.
4. If I elect to enroll in any of the insurance Plans offered by the Village, I authorize the deduction from my earnings of the required premiums.
5. I understand my contributions for medical will be deducted every pay period on a pre-tax basis and this election cannot be revoked or changed during the plan year, unless there is a change in status, which justifies the revocation or change.
6. I certify that the foregoing information is true and correct.

_____ _____ _____

Employee Printed Name | Employee Signature | Date