GIS | Benefits
OUR PLAN. YOUR CHOICE.

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	Group ID:	Group Policy #:	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name **Village of Oak Lawn**	County	Employer ZIP	State
Employee First Name / Middle Initial / Last Name	Social Security Number		Date of Birth
Street Address / City / State / Zip			
Gender:	Marital Status:	Email:	Work Phone

Employee Work Information (Complete for ALL Enrollments)

Average Work Week:	Occupation:	Earnings:	Full-Time Employment:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Monthly Deduction
Legal Plan + 20 Hours Divorce Provided By: MetLegal	☐**Yes** ☐**No*** ***price is the same for employee only and covering dependents**	☐**Employee Only** ☐**Employee/Spouse** ☐**Employee/Children** ☐**Employee/Spouse/Children**	$21.75 $21.75 $21.75 $21.75

*By selecting no, application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense. Actual deductions may vary slightly from above illustration due to rounding

Dependent and Other Insurance Information (Complete for All Dependent Coverage)

	Last Name	First Name	Social Security #	Gender	Date of Birth
Spouse:					
Children: **Full Time Student ____**					
Full Time Student ____					
Full Time Student ____					

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Required Notice: Boon-Chapman Benefit Administrators, Inc. is a third party administrator that provides premium billing services for the insurance companies offering coverage under this Form.

Signature Section:
I acknowledge I have received and reviewed enrollment materials explaining the benefits offered and the exclusions, limitations and reductions that apply. I understand that the effective date of coverage will vary based on contract terms. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.
On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name:
Employee Signature: _____ Date:_____