BlueCross BlueShield of Illinois

# Marmon Healthcare Plan

**Eligible Employee**

Cerro Wire

**ENROLLMENT TYPE:** OPEN ENROLLMENT ☐ NEW HIRE ☐ CANCEL ☐ CHANGE ☐

COBRA ☐ Reason: _____ Start Date ___/___/___ End Date ___/___/___

**MEDICAL PLAN OPTION:** Plan B ☐ Plan D ☐ Plan H ☐ Waive ☐

**COVERAGE LEVEL:** Employee Only: ☐ Employee + Spouse: ☐ Employee + Dependent(s): ☐ Family: ☐

## EMPLOYEE INFORMATION

**LAST NAME** _____ **FIRST NAME** _____ **MI** _____

**ADDRESS** _____ **APT #** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

**DATE OF BIRTH** ___/___/____ **SOCIAL SECURITY #** ___-___-____ **GENDER** MALE: ☐ FEMALE: ☐

**PHONE** _____ **EMAIL** _____

## OTHER COVERAGE / MEDICARE INFORMATION

Are YOU covered under your employer's health care plan and also covered by Medicare? **Yes** ☐ **No** ☐ If yes, complete this section.

**HIC Number:** _____

**MEDICARE A:** ☐ **MEDICARE B:** ☐ **End Stage Renal Dialysis (ESRD):** ☐ **DISABILITY:** ☐

**START DATE:** ___/___ **END DATE:** ___/___

## FAMILY INFORMATION

**FAMILY COVERAGE INFORMATION: List all Eligible Dependents and Type of Coverage.**

| Name (Last, First, MI) | Social Security Number | Date of Birth | Medical (Y/N) | Dental (Y/N) | Gender | Relationship |
|---|---|---|---|---|---|---|
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |
| | | / / | | | | |

***If any of the dependents listed above are covered by any OTHER GROUP COVERAGE, please complete the information below.***

**INSURED'S NAME** _____ **POLICY NUMBER** _____

**INSURANCE COMPANY NAME** _____

**EMPLOYED BY** _____ **INDIVIDUAL** ☐ **FAMILY** ☐

**INSURANCE COMPANY ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____ **PHONE** _____

***If any of the dependents listed above are covered by MEDICARE, please complete the information below.***

**MEDICARE A:** ☐ **MEDICARE B:** ☐ **End Stage Renal Dialysis (ESRD):** ☐ **DISABILITY:** ☐

**HIC NUMBER** **START DATE** ___/___ **END DATE** ___/___

**APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation. I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Employee Signature _____ Date _____

**I DO NOT WISH TO ENROLL** at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Employee Signature _____ Date _____

**OFFICE USE ONLY**

**COVERAGE EFFECTIVE DATE:** _____/_____/_____ **DATE OF HIRE:** ___/___/____ **Coverage Change Date:** _____/_____/_____

**COMPLETED and CHECKED by:** _____

**COMPANY NAME** _____ **LOCATION:** Cerro Wire - AL / GA / IN / UT

**MEDICAL GROUP # (if Enrolled):** _____

**MEDICAL SECTION # (if Enrolled):** _____

MEDICAL Group Number : _____

MEDICAL Section Number : _____

**Employee Type:** _____
HR - Hourly
SE - Salaried Exempt
SN - Salaried Non-Exempt

**Employee Status:** _____
A Active
C COBRA
L LTD

**Union Status:** _____
U - Union
N - Non-Union

# FSA Election Form

Date: _____

Fax- # of Pages: _____

## Personal Information (*Required)

*Company Name: _____ *Effective Date of Election: ___/___/___

*Employee Name: _____ *Gender: _____

Date of Hire: ___/___/___ *SSN: _____ *Date of Birth: ___/___/___

*Address: _____ *City: _____ *State: _____ *Zip Code: _____

Phone Number: _____ Fax Number: _____ *Email Address: _____

## Enter Annual Election

| FSA Elections | Annual Election Amount | Pay Period Frequency (W, B, S or M*) | First Payroll Date Affected |
|---|---|---|---|
| **Health Care FSA**** | $ _____ | _____ | _____ |
| **Limited Purpose FSA**** | $ _____ | _____ | _____ |
| **Dependent Care FSA** | $ _____ | _____ | _____ |

Remember, when your needs change, FlexFSA does too! You can change your premium elections any time you have a qualifying event that would change the status and/or premium amount of your employee insurance (i.e. marriage, divorce, birth or death of a child, death of a spouse, adoption or change of employment by spouse).

***Pay Period Frequency: W = Weekly; B = Biweekly; S = Semi-monthly; M = Monthly**

****If you have an HSA, you are only eligible to participate in a Limited Purpose FSA if offered by your employer**

## Acknowledgement and Signature

☐ I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax column above. I recognize that these selections constitute a deliberate binding decision on my part that may not be changed until the enrollment period for the next plan year or if I experience a change in status

Employee Signature: _____ Date: _____

**OR**

☐ I elect **NOT** to participate in any portion of the FlexFSA plan. (i.e FSA, Dependent Care, Limited Purpose).

Employee Signature: _____ Date: _____

***Save and Spend Healthy*** On-the-Go

**Download the free**
**My Flex Account**
**mobile app today!**

Download on the App Store

Google play

##24T01408##################

f: 844-859-7306 // service@myflexaccount.com
8700 W. Bryn Mawr Avenue, Suite 1010S, Chicago, IL 60631

myflexaccount.com