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

Health Savings Account Contribution Authorization Form

Follow these easy steps:

1. Complete all entries on this authorization form.
2. Print, sign and date this form.
3. Submit it to your Human Resources Department.
4. Open your HSA online. You will receive additional instructions following the enrollment period.

Health Savings Account Qualification

Your Health Savings Account is your financial asset even if you change employers or health plans. To be eligible for a Health Savings Account you must meet three criteria:

1. You must be covered by a qualified high deductible plan
2. You cannot be covered by another health plan, including Medicare or Flexible Spending Accounts (you may be enrolled in a Limited Use Flexible Spending Account if offered by your employer or your spouse's employer)
3. You cannot be claimed as a dependent on another individual's tax return

Open Your Account Online

After the enrollment period, you will receive additional instructions for opening your Health Savings Account online. The instructions are usually emailed, so please enter your email address below.

Personal Information

Employee Name (last name, first name)	Social Security Number
Street Address (can not be PO Box)	City, State, Zip Code , ,
Mailing Address (if different)	City, State, Zip Code , ,
Day Time Phone Number	Email Address
Date of Birth / /	Enrollment Status ☒ New participant ☐ Re-enrollment

Pre-Tax HSA Contributions

You can elect to make pre-tax contributions to an HSA through payroll deduction. Please indicate your pre-tax payroll deduction amount here.	Annual Pre-Tax HSA Contribution Amount $ (Not to exceed IRS maximum)	Per pay period $

Authorization and Certification

- I am authorizing my employer to reduce my compensation by the amount specified.
- I understand that after the enrollment period, I will receive additional instructions for opening my Health Savings Account (HSA) with the custodian.

Employee Signature

/ /
Date