



BlueCross BlueShield
of Illinois

Marmon Healthcare Plan

Eligible Employee
Cerro Wire

ENROLLMENT TYPE:

☐ NEW HIRE ☐ CANCEL ☐ CHANGE ☐

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

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

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: _____ Employee Type: _____ Employee Status: _____ Union Status: _____
HR - Hourly A Active U - Union
MEDICAL Section Number: _____ SE - Salaried Exempt C COBRA N - Non-Union
SN - Salaried Non-Exempt L LTD

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!



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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	Per pay period
	\$ (Not to exceed IRS maximum)	\$

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