VILLAGE OF HOFFMAN ESTATES · H E · 19 59 · GROWING TO GREATNESS

Village of Hoffman Estates

Benefits Enrollment Form

Return your completed and signed form to HRM within 30 days of your first day of employment or within 30 days of your qualified status change.

Your Personal Information

Enrollment Type:

Name (Last, First, Middle Initial)		Effective Date	Social Security Number
Street Address	City, State, Zip		Primary Phone Number
Email Address:			

Changes to Existing Coverage

Add Dependents
Date: ___________
☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other:
____

Cancel Dependents
Date: ____________
☐ Divorce
☐ Age Limit
☐ Other: _________________

Cancel
Date: ____________
☐ Terminate Coverage
☐ Other: _____________
____
____
____

Persons to be Enrolled/Dependent Information

Last Name (If different from Employee)	First Name	Social Security No.	Relationship	Gender (M/F)	D.O.B.	Health Plan (y/n)	Dental Plan (y/n)	Vision Plan (y/n)

Health Plan

Effective Date: _______________

Select one health plan and one coverage level:

☐ PPO1 - ☐ Employee ☐ Family
☐ PPO2 - ☐ Employee ☐ Family
☐ PPO3 - ☐ Employee ☐ Employee+1 ☐ Family
☐ HMO - ☐ Employee ☐ Family
*If choosing HMO – see below for additional information needed
☐ HSA - ☐ Employee ☐ Family

Are you or any dependents covered by Medicare? ☐ Y ☐ N – If yes, see HRM for additional information needed.

Dental Plan

Effective Date:_______________

Select one health plan and one coverage level:

☐ PPO1 - ☐ Employee ☐ Employee+1 ☐ Family
☐ PPO2 - ☐ Employee ☐ Employee+1 ☐ Family
☐ PPO3 - ☐ Employee ☐ Employee+1 ☐ Family

Vision Plan

Effective Date: ________________

Select one:

☐ Employee
☐ Family

I APPLY FOR COVERAGE AS INDICATED ABOVE – I have completed the above form and attest that all of the information provided is true and complete to the best of my knowledge. I understand that I am required to furnish proof of relationship for dependents added to the insurance coverage (marriage certificate, divorce decree, court documents establishing guardianship or adoption and/or the birth certificate for any individual for whom I seek benefits).

____   ____________________
Signature of Applicant   Date Signed

HRM Use Only

Dependent Verification Type:

*For HMO Participants:

Employee: ______________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No

Dependent Name: __________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No

Dependent Name: __________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No

Dependent Name: __________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No

Dependent Name: __________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No

Dependent Name: __________________________

Medical Group/IPA#: _______________ Medical Group/IPA Name: ________________________________
WPHCP Medical Group/IPA#:___________WPHCP (Medical Group Name): _______________________________
Are you already a patient? ☐ Yes ☐ No