ILLINOIS SCHOOL
Insurance Network

DIV 08 - Laraway Community Consolidated School District 70C

Enrollment / Change Checklist

TO BE COMPLETED BY EMPLOYER

Employee Name:	
Reason for Enrollment / Change:	☐ New Hire ☐ Birth ☐ Job Status Change ☐ Marriage ☐ Lost Other Coverage ☐ Other | Describe:_____ ☐ Open Enrollment
Coverage Elected	
Medical Insurance BCBS of IL	☐ Enrolled in PPO/HDHP ☐ Enrolled in HMO ☐ Confirm Medical Group # provided on application ☐ Waived Medical
Dental Insurance BCBS of IL	☐ Enrolled in Dental ☐ Waived Dental
Vision Insurance VSP	☐ Enrolled in Vision ☐ Waived Vision
Life/AD&D Insurance BCBS of IL (Dearborn) Employee Salary:_____ Benefit Class:_____	☐ Basic Life/AD&D | Benefit Amount: $_____ ☐ Enrolled in Voluntary Life/AD&D | Employee Amount: $_____ ☐ Evidence of Insurability (EOI) Needed | Spouse Amount: $_____ | Child(ren) Amount: $_____ ☐ Waived Voluntary Life/AD&D

Employees: Please submit along with all other required forms to your HR Department contact.

HR Department: Please submit along with all other required forms to:

Illinois School Insurance Network

Email: mwil.isinadministration@marshmma.com

As of 01.01.2026

EIN: 36-6008373

Benefit Election & Waiver Form

LARAWAY CCSD 70C: ALL ELIGIBLE EMPLOYEES

Please complete the following election form for your benefits. Select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered, and are therefore waiving all coverage, please check the box for waiving coverage under each benefit. The top portion of this form must be completed in its entirety. Form is not valid unless signed.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Qualifying Life Event* (Please Describe)** _____

**Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*
*** Please note that all employees will be enrolled in employer-sponsored Basic Life & AD&D.*

REQUIRED INFORMATION

District Name: Laraway CCSD 70C
Employee Name: _____
Address: _____
City, State, Zip: _____
Date of Birth: / / Gender: ☐ M ☐ F
Email: _____

Social Security #: — —
Date of Hire: / /
Coverage Effective: / /
Telephone #: — —
Marital Status: _____

Medical Coverage Election

☐ I choose to waive medical coverage for the plan year. **BCBS of Illinois**

	BA HMO** Plan 3 B14332	BA HMO** Plan 4 B01776	PPO 165608	PPO 165607	HDHP w/ HSA 165602
Employee Only	☐	☐	☐	☐	☐
Employee + 1*	☐	☐	☐	☐	☐
Family*	☐	☐	☐	☐	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

****If you select HMO, you must provide a Medical Group # and PCP Information on the next page.**

Dental Coverage Election

☐ I choose to waive dental coverage for the plan year. **BCBS of Illinois**

	DPPO 1500 270729	DPPO 2000 270736
Employee Only	☐	☐
Employee + 1*	☐	☐
Family*	☐	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

Vision Coverage Election

☐ I choose to waive vision coverage for the plan year. **VSP**

	Vision Plan 175 12019596
Employee Only	☐
Employee + 1*	☐
Family*	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					

Medical PCP Information

THIS INFORMATION IS REQUIRED IF ENROLLING IN MEDICAL HMO PLAN

Name of Enrolled	Medical PCP Name	9-Digit PCP ID Number	3-Digit Medical Group/ IPA Number

Basic Life / AD&D Beneficiaries — BCBS of Illinois

Laraway CCSD 70C provides a **$25,000** Basic Life/AD&D benefit. Please list the beneficiaries you wish to have on file.

Primary Beneficiary Full Name	Address	Social Security #	Date of Birth	Relationship	Benefit %
		- -	/ /		%
		- -	/ /		%
		- -	/ /		%
Total (must equal 100%)					%

Contingent Beneficiary Full Name	Address	Social Security #	Date of Birth	Relationship	Benefit %
		- -	/ /		%
		- -	/ /		%
		- -	/ /		%
Total (must equal 100%)					%

Voluntary Life / AD&D Coverage (employee is responsible for the full cost of premium) — BCBS of Illinois

☐ I choose to **elect** Voluntary Life/ AD&D coverage (indicate amount below) ☐ I choose to **waive** Voluntary Life /AD&D coverage

Type	Benefit Amount Offered	Guarantee Issue Amount	Life / AD&D Coverage Elected	Life Coverage Elected
Employee	Elect up to $100,000 in $25,000 increments, not to exceed 5x annual earnings	$100,000, Not to exceed 3x earnings	$	
Spouse	Elect up to $50,000 in $10,000 increments, not to exceed 50% of employee election	$20,000		$
Child(ren)	15 Days - 6 Months: $500; 6 months to age 26: $5,000 Dependent child(ren) rate covers all eligible children	$5,000		$

Monthly Rate Table - Please select your age band as of the benefit effective date. Spouse rate is based on spouse age.

Age Band	Employee Rate per $25,000	Spouse Rate per $10,000	Age Band	Employee Rate per $25,000	Spouse Rate per $10,000	Age Band	Employee Rate per $25,000	Spouse Rate per $10,000
<25	☐ $2.05	☐ $0.62	**40-44**	☐ $3.58	☐ $1.23	**60-64**	☐ $20.88	☐ $8.15
25-29	☐ $2.35	☐ $0.74	**45-49**	☐ $5.13	☐ $1.85	**65-69**	☐ $39.73	☐ $15.69
30-34	☐ $2.98	☐ $0.99	**50-54**	☐ $7.60	☐ $2.84	**70-74**	☐ $64.10	N/A
35-39	☐ $3.28	☐ $1.11	**55-59**	☐ $13.78	☐ $5.31	**75+**	☐ $64.10	N/A
			Child(ren) Rate per $5,000	☐ $0.63				

***NOTE:** You must complete the **Evidence of Insurability** form if (1) You previously waived or did not enroll when you first became eligible; (2) You have elected to purchase more than **the Guarantee Issue** for Employee Coverage; (3) You have elected to purchase more than **$20,000** for Spouse Coverage; (4) you have elected to purchase any amount of coverage for your spouse and/or child(ren) that previously waived or did not enroll when you first became eligible. You must purchase coverage for yourself in order to purchase coverage for your spouse and/or child(ren). Late entrants and amounts over the Guarantee Issue are subject to underwriting approval. Coverage will begin on the first of the month following approval. In some instances, a physical exam by a doctor may be required. The dependent child(ren) rate covers all eligible children.*

Voluntary Life / AD&D Beneficiaries — BCBS of Illinois

Primary Beneficiary Full Name	Address	Social Security #	Date of Birth	Relationship	Benefit %
		- -	/ /		%
		- -	/ /		%
		- -	/ /		%
Total (must equal 100%)					%

Contingent Beneficiary Full Name	Address	Social Security #	Date of Birth	Relationship	Benefit %
		- -	/ /		%
		- -	/ /		%
		- -	/ /		%
Total (must equal 100%)					%

Health Savings Account (HSA) Election

☐ I choose to **contribute** to an HSA (indicate amount below) ☐ I choose to **not to contribute** to an HSA

If you have elected the High Deductible Health Plan (HDHP), you may open a Health Savings Account. See your HR representative with questions.

	Employee Only	Family *(Employee + 1 or more)*
Maximum IRS Annual HSA Contributions 2026	$4,400	$8,750
"Catch-Up" Contributions (individuals aged 55 and older)	Additional $1,000	Additional $1,000
Your **Monthly** Contribution:	$_____ per month	$_____ per month

**Once enrolled in Medicare, you are no longer eligible to contribute to your HSA account.*

Flexible Spending Account (FSA) — EBC

☐ I choose to contribute toward the Health Care FSA	Annual Amount: $_____	**Maximum Contribution Allowance:** $3,400
☐ I choose to contribute toward the Dependent Care FSA	Annual Amount: $_____	**Maximum Contribution Allowance:** $7,500 ($3,750 if single or married, filing separately)

Health Care FSA Dollars have a "use it or lose it" provision. You can roll over any amount year to year up to $680, but anything above $680 will be forfeited. FSA Dollars can only be used for qualified medical expenses, which can be found here: https://www.irs.gov/pub/irs-pdf/p502.pdf

Voluntary Accident Insurance — ☐ I choose to waive this coverage for the plan year. — BCBS of Illinois

Employee Only ☐

Employee + Spouse ☐

Employee + Child(ren) ☐

Family ☐

Voluntary Hospital Indemnity Insurance ☐ I choose to waive this coverage for the plan year. BCBS of Illinois

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Voluntary Critical Illness Insurance BCBS of Illinois

☐ I choose to **elect** Critical Illness coverage (indicate amount below) ☐ I choose to **waive** Critical Illness coverage

Elect Coverage Amount

Employee	☐ $5,000 ☐ $10,000	☐ $15,000 ☐ $20,000	
Spouse	☐ $2,500 ☐ $5,000	☐ $7,500 ☐ $10,000	Date of Birth: ____/____/_____
Child(ren)	☐ $2,500 ☐ $5,000	☐ $7,500 ☐ $10,000	

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during the next open enrollment period, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact your Benefits Department within 30 days of the life status change.

My signature below authorizes Laraway Community Consolidated School District 70C to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: ____/____/____