UNIVERSITY OF ILLINOIS
URBANA-CHAMPAIGN • CHICAGO • SPRINGFIELD

BasicCare Program

Enrollment Form

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOU

Social Security Number   First Name   Middle Initial   Last Name

Mailing Address: Street   City

State   Zip   Home Phone Number   Birth Date: Month Day Year   Sex: ☐ M ☐ F

University of IL

Name of Employer   Work Phone Number

SECTION B — ENROLLMENT SELECTION

It is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollment may be delayed. Costs listed below are **monthly** amounts.

Make your selection by putting an X in the box next to the selection you want. You must mark a box in each section. You may elect both BasicAdvantage Total and Essential plans. List your Dependents on the back of this form.

	BasicAdvantage Total Plan	Essential Plan[1]	Dental Plan	Term Life / STD Plans[2]
Employee Only	☐ $0	☐ $0	☐ $19.28	☐ $18.42
Employee + Spouse	☐ $56.72	☐ $20.95		
Employee + One Child	☐ $25.57	☐ $38.24		
Employee + Children	☐ $78.17	☐ $80.30		
Employee + Family	☐ $120.55	☐ $99.42	☐ $55.25	☐ $19.28
DECLINE COVERAGE	☐	☐	☐	☐

[1] The costs shown include amounts paid for Affordable Care Act excise taxes (those monthly amounts are: $3.55—Employee Only, $6.32—Employee + Spouse, $6.84—Employee + One Child, $10.46—Employee + Children, $12.10—Employee + Family) and a processing fee (those monthly amounts are: $2.92—Employee Only, $4.34—Employee + Spouse, $4.34—Employee + One Child, $5.90—Employee + Children, $6.61—Employee + Family) that are in addition to the plan's premium.

[2] STD Coverage is only available for employees (no dependent coverage) and is not available for employees who work in CA, HI, NJ, NY, RI, or Puerto Rico. The **monthly** costs for Term Life only are: **$3.25** for Employee Only, or **$4.12** for Employee + Family coverage.

I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct the required costs from my paycheck. I understand and agree that any Term Life Plan benefits payable upon my death will be paid in equal shares to members of the first surviving beneficiary class, as follows: spouse; children; parents; brothers and sisters; or, if none, then my estate.

Your Signature   Today's Date: Month Day Year

(OVER PLEASE)

SECTION C — WHICH DEPENDENTS WILL BE COVERED?

1. First Name Middle Initial Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan ☐ Dental Plan ☐ Term Life Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

2. First Name Middle Initial Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan ☐ Dental Plan ☐ Term Life Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

3. First Name Middle Initial Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan ☐ Dental Plan ☐ Term Life Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

4. First Name Middle Initial Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan ☐ Dental Plan ☐ Term Life Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

Address of Dependent not living with you:

First Name Middle Initial Last Name

Mailing Address: Street City State Zip

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.

There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Periods. Please ask your employer for a Life Event Change Form which must be used for the additions or changes to benefits (including Special Enrollments), outside of an Open Enrollment Period.