2021 East Central College

Employee Medical Insurance Election Form

Instructions: Please review the information listed below and make sure all data is correct including your address, phone and work phone. If any of the data listed below is incorrect, please mark through it and write in the correct information. Your current enrollments are indicated in the "Current Medical" column. If you desire to change your current enrollment, indicate by placing an **"X"** in the appropriate box for add or delete. If you wish to cover a dependent that is not listed on the form, please write their name and corresponding information in the space provided below and place an **"X"** in the add column. Recent healthcare legislation now allows for dependent children to be covered on their parent's insurance plan through the end of the month in which they turn age 26 regardless of student status, marital status and access to other coverage.

This form must be completed and returned to Human Resources

Relationship	Social Security Number	Last Name	First Name	Middle Initial	Gender	D.O.B.	Current Medical	Add/Delete to Medical	Effective Date
Employee									
Spouse									
Child 1									
Child 2									
Child 3									
Child 4									

SELECT YOUR PLAN AND NETWORK ELECTIONS BELOW:

1. Medical Coverage Requested: ☐ **Employee/Retiree** ☐ **Employee/Retiree & Spouse** ☐ **Employee/Retiree & Child (ren)**

☐ **Employee/Retiree & Family** ☐ **I elect to waive my coverage**

2. Select a Plan: ☐ **Base Plan** ☐ **H.S.A. Plan**

3. Select One Network Only:

☐ **Anthem Blue Access Choice (BAC) Network** **The BAC Network includes BJC Hospital Providers**	☐ **Anthem Blue Preferred Select (BPS) Network** **The BPS Network DOES NOT include the following BJC Hospital Providers:**

Employee Home Address: ______________________ **City:** ______________________ **State:** __________ **Zip Code:** ______________

Contact Phone Number: ______________________________ **Employee Hire Date:** ______________________________

By signing this form you acknowledge that the above information is accurate and the dependents listed meet all legal requirements to be eligible for coverage under this insurance plan. These are your medical elections for the plan year 01/01/2021 – 12/31/2021. No changes can be made to the benefits during the plan year unless you have a "qualified life changing event".

4. Employee Signature: ______________________________________ **Date:** ______________________