EMPLOYEE SELECTION FORM FOR MEDICAL INSURANCE
FOR THE PLAN YEAR OF JUNE 1, 2018 TO MAY 31, 2019

I, ________________________________, hereby make the following selection for my group health insurance coverage for the plan year of June 1, 2018 through May 31, 2019.

______ OPTION 1 – PPO – Silver Blue Choice Preferred (S532BCE).

IF YOU SELECT THIS OPTION 1, PLEASE SIGN AND DATE THE FORM BELOW AND COMPLETE THE ATTACHED FLEXIBLE SAVINGS ACCOUNT FORM INDICATING IF YOU WANT THE CONTRIBUTION TO BE MADE ON PRE-TAX OR AFTER-TAX BASIS.

YOU MUST SELECT ONE OF THE BELOW CLASSES OF COVERAGE:

______ Employee Only Coverage – Medical, Dental and Vision

______ Employee Plus Spouse – Medical, Dental and Vision

______ Employee Plus Child(ren) Coverage – Medical, Dental and Vision

______ Family Coverage – Medical, Dental and Vision

______ OPTION 2 – HMO – Gold Blue Precision (G532PSN). **PCP Information found at the end of this form must be completed.**

IF YOU SELECT THIS OPTION 2, PLEASE SIGN AND DATE THE FORM BELOW AND COMPLETE THE ATTACHED FLEXIBLE SAVINGS ACCOUNT FORM INDICATING IF YOU WANT THE CONTRIBUTION TO BE MADE ON PRE-TAX OR AFTER-TAX BASIS.

YOU MUST SELECT ONE OF THE BELOW CLASSES OF COVERAGE:

______ Employee Only Coverage – Medical, Dental and Vision

______ Employee Plus Spouse – Medical, Dental and Vision

______ Employee Plus Child(ren) Coverage – Medical, Dental and Vision

______ Family Coverage – Medical, Dental and Vision

______ OPTION 3 – HMO – Platinum Blue Precision (P506PSN). **PCP Information found at the end of this form must be completed.**

IF YOU SELECT THIS OPTION 3, PLEASE SIGN AND DATE THE FORM BELOW AND COMPLETE THE ATTACHED FLEXIBLE SAVINGS ACCOUNT FORM INDICATING IF YOU WANT THE CONTRIBUTION TO BE MADE ON PRE-TAX OR AFTER-TAX BASIS.

YOU MUST SELECT ONE OF THE BELOW CLASSES OF COVERAGE:

______ Employee Only Coverage – Medical, Dental and Vision

______ Employee Plus Spouse – Medical, Dental and Vision

______ Employee Plus Child(ren) Coverage – Medical, Dental and Vision

______ Family Coverage – Medical, Dental and Vision

______ OPTION 4 – PPO – Blue Options (G506OPT).

IF YOU SELECT THIS OPTION 4, PLEASE SIGN AND DATE THE FORM BELOW AND COMPLETE THE ATTACHED FLEXIBLE SAVINGS ACCOUNT FORM INDICATING IF YOU WANT THE CONTRIBUTION TO BE MADE ON PRE-TAX OR AFTER-TAX BASIS.

YOU MUST SELECT ONE OF THE BELOW CLASSES OF COVERAGE:

______ Employee Only Coverage – Medical, Dental and Vision

______ Employee Plus Spouse – Medical, Dental and Vision

______ Employee Plus Child(ren) Coverage – Medical, Dental and Vision

______ Family Coverage – Medical, Dental and Vision

I understand that the selection of Options 1, 2, 3 or 4 will require a premium contribution from me, to be made through payroll deduction, and that my selection cannot be changed during the plan year of June 1, 2018 to May 31, 2019. I also understand that these payroll deductions are delayed by three pay periods from the start of the Plan Year. I also agree to allow the District to deduct any premium contribution that may be due from me upon my termination of employment.

______ I have had a chance to review all of the options offered by the District and wish to waive the following coverage:

IF WAIVING, YOU MUST SELECT ONE OF THE BELOW WAIVERS:

______ Waiving Medical, Dental and Vision Coverage

______ Waiving Medical and Dental Coverage Only

______ Waiving Dental and Vision Coverage Only

______ Waiving Medical Coverage Only

______ Waiving Dental Coverage Only

______ Waiving Vision Coverage Only

I have read and understand the above information.

____ ________________________

Signature Date

PRIMARY CARE PROVIDER (PCP) INFORMATION SECTION (only to be filled out if you selected Options 2 or 3 above)

Please list below the following information for the subscriber (employee) and all covered dependents that are being enrolled in one of the above HMO plans offered by the District. Failure to provide this information will delay your enrollment and may make it difficult to properly receive benefits for care provided through your PCP.

Covered Individual	Doctor's Name	PCP #	Medical Group Name	Medical Group/IPA #

DOWNERS GROVE SANITARY DISTRICT FLEXIBLE COMPENSATION PLAN

AUTHORIZATION FOR BEFORE-TAX OR AFTER-TAX GROUP MEDICAL INSURANCE CONTRIBUTIONS

JUNE 1, 2018 – MAY 31, 2019

PURPOSE OF THIS FORM AND IMPORTANT NOTICE

This form is used to elect pre-tax (premium conversion) under the Downers Grove Sanitary District Flexible Compensation Plan (the "Plan") of employee premium contributions or after-tax treatment of employee premium contributions for group health coverage. You must return this form to Clay Campbell on or before May 31, 2018.

I. PARTICIPANT INFORMATION

Last Name	First Name	MI	Last Four of SSN

II. ELECTION TO PARTICIPATE IN PREMIUM CONVERSION (COMPLETE THIS SECTION FOR PRE-TAX BASIS ONLY)

- ❑ Enroll me in the Premium Conversion for group health coverage (The first box in Section III must also be checked if you select this option).

I authorize Downers Grove Sanitary District to deduct the total required premium contribution under the Flexible Spending Account Premium Conversion Benefit from my paychecks paid beginning July 17, 2018 (Supervisors) and July 20, 2018 (Hourly). The deductions will be made in equal amounts from each paycheck. These amounts will be deposited into an account maintained by the Downers Grove Sanitary District and used for my premium conversion payment. This is my initial opportunity to participate in the Premium Conversion Benefit.

III. ELECTION TO PARTICIPATE/WAIVE PARTICIPATION IN PREMIUM CONVERSION BENEFIT (CHOOSE ONE)

- ❑ I elect to have the entire required portion of my group health insurance premium contribution deducted from my pay on a **pre-tax** basis.
- ❑ I elect to waive participation in the Plan's Premium Conversion Benefit. I would like to have my entire monthly required group health insurance premium contribution deducted from my pay on an **after-tax** basis.

I understand that I may only change my premium deductions to either an after-tax or pre-tax basis during a subsequent open enrollment period or upon a Qualifying Life Event as described in the Summary Plan Description.

IV. ATTESTATIONS

I understand that the election I have made above will take effect no earlier than June 1, 2018 and will remain in effect unless a Qualifying Life Event as described in the Summary Plan Description occurs or I elect to change my premium deductions to either an after-tax or pre-tax basis during a subsequent open enrollment period. I also understand that I cannot transfer money between my health care reimbursement account, my dependent care reimbursement account, or this premium conversion account, if I participate in any of those accounts.

Finally, I understand that if I have selected the pre-tax contribution (Premium Conversion Benefit), the amount(s) withheld will reduce my gross wages for purposes of calculation of any benefits that I may be entitled to under either Social Security or the Illinois Municipal Retirement Fund.

I hereby agree to have the Downers Grove Sanitary District reduce my pay in the manner I have designated above.

Signature: Date: / /

V. TO BE COMPLETED BY PAYROLL/PERSONNEL STAFF

Approved ☐ Disapproved ☐ Effective Date: 06/01/2018

Received by: ______________________ Date: ______________________