win
wellness insurance network

Benefit Election & Waiver Form

Please complete the following election form for your benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by WIN and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form. If waiving all but basic life, be sure to fill out beneficiary information.

☐ Open Enrollment	☐ New Hire	☐ Change of Status* Reason:_____	☐ Waiving All Coverage

*Change of Status is only applicable if you have experienced a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth/adoption of a child.

Library Name:		Coverage Efectve:
Employee Name (please print):		Date of Hire:
Address:		City/State/Zip Code:
Date of Birth:	Gender:	Telephone Number:
Social Security #:	Annual Salary:	Marital Status:

Medical Coverage

BlueCross BlueShield

Election	Plan A	Plan B	Plan C
Employee Only	☐	☐	☐
Employee + Spouse	☐	☐	☐
Employee + Child(ren)	☐	☐	☐
Family	☐	☐	☐
☐ I am choosing to waive medical coverage.			

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section below.

Dental Coverage

BlueCross BlueShield

Election	Dental PPO
Employee Only	☐
Employee + One	☐
Family	☐
☐ I am choosing to waive dental coverage.	

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section below.

Dependent Information

Name	Social Security #	Birthdate	Gender	Relationship	Medical	Dental
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Basic Life/AD&D, Short-Term Disability, & Long-Term Disability—

☐ Please check here if you are making a change or new enrollment on your Basic Life/AD&D, Short-Term Disability, or Long-Term Disability insurance.

BlueCross BlueShield

Election			
Basic Life and AD&D	☐	I am choosing to waive Basic Life and AD&D	☐
Short Term Disability	☐	I am choosing to waive Short-Term Disability	☐
Long Term Disability	☐	I am choosing to waive Long-Term Disability	☐

Basic Life/AD&D Coverage—Please list below the beneficiaries that you want to have on file. BlueCross BlueShield

Primary Beneficiary Full Name	Address	Date of Birth	Relationship to Employee	Benefit Percentage
				%
				%
				%
Total (must equal 100%)				100%

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship to Employee	Benefit Percentage
				%
				%
				%
Total (must equal 100%)				100%

Authorization and Signature

Every employee is required to complete this form, in its entirety. You will not have to fill out carrier enrollment applications in addition to completing this form. Your next opportunity to make changes will be during open enrollment period in late fall for a January 1st effective date, 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

Name:	Signature:	Date: