City of Highland Park — Benefits Enrollment Form

Please complete the following information. If opting out of any city-sponsored benefits, please complete the 'Demographic Information,' select 'opt out' in each section, and sign and date the form. Dependent information is only required if participating in benefits.

Demographic Information

Effective Date	Reason for completing this form:	New Hire	Open Enrollment	Qualifying Life Event

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address	Unit #	City	State	Zip Code

Primary Phone Number	Male	Female	Nonbinary	Email Address

Medical Insurance Election
Blue Cross Blue Shield of Illinois

PPO HCA (BCO) - 47753 ☐ PPO Plus (BCO) - 47751 ☐ PPO Base (BCO) - 47752 ☐ BA HMO - B04714 ☐ Opt Out of Medical Coverage ☐

For BA HMO Plan Only

PCP/IPA Name & PCP/IPA #	Are you an existing patient?	Yes	No	OB/GYN Name &OB/GYN # (if applicable)	Are you an existing patient?	Yes	No
		☐	☐			☐	☐

Dental Insurance Election
Delta Dental of Illinois

Opt Into Dental Coverage ☐ Opt Out of Dental Coverage ☐

Flexible Spending Account
Wex Health

Please consult with Wex Health or the IRS for the most up-to-date maximums for each category.

	Amount Deducted Per Pay Period	Number of Pay Periods	Annual Election Amount	- Or -
Medical Expenses ($3,500 annual maximum for 2027)	$	x 26	=	**Opt Out** ☐
Dependent Care ($7,500 annual maximum for 2027)	$	x 26	=	**Opt Out** ☐
Commuter Benefits ($350 monthly maximum for 2027 or $161.53 per period)	$	x	=	**Opt Out** ☐

Please complete the dependent information on the next page if applicable.

Signature: _____ Date: _____

City of Highland Park — Benefits Enrollment Form

Please note the grey sections are <u>for the BA HMO plan only</u>. An additional dependent page is available if need-

Dependent Information

Spouse/Partner (skip if not applicable)

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address (if different)	Unit #	City	State	Zip Code

Spouse	Civil Union Partner	Male	Female	Nonbinary	Medical	Dental	Flex Spend
☐	☐	☐	☐	☐	☐	☐	☐

PCP/IPA Name & PCP/IPA #	Are they an existing patient?	Yes	No	OB/GYN Name &OB/GYN #	Are they an existing patient?	Yes	No
		☐	☐			☐	☐

Child/Dependent

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address (if different)	Unit #	City	State	Zip Code	Are they a full time student?	Yes	No
						☐	☐

Biological Child	Adopted Child	Stepchild	Legal Guardianship	Male	Female	Nonbinary	Medical	Dental	Flex Spend
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PCP/IPA Name & PCP/IPA #	Are they an existing patient?	Yes	No	OB/GYN Name &OB/GYN #	Are they an existing patient?	Yes	No
		☐	☐			☐	☐

Child/Dependent

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address (if different)	Unit #	City	State	Zip Code	Are they a full time student?	Yes	No
						☐	☐

Biological Child	Adopted Child	Stepchild	Legal Guardianship	Male	Female	Nonbinary	Medical	Dental	Flex Spend
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PCP/IPA Name & PCP/IPA #	Are they an existing patient?	Yes	No	OB/GYN Name &OB/GYN #	Are they an existing patient?	Yes	No
		☐	☐			☐	☐

Child/Dependent

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address (if different)	Unit #	City	State	Zip Code	Are they a full time student?	Yes	No
						☐	☐

Biological Child	Adopted Child	Stepchild	Legal Guardianship	Male	Female	Nonbinary	Medical	Dental	Flex Spend
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PCP/IPA Name & PCP/IPA #	Are they an existing patient?	Yes	No	OB/GYN Name &OB/GYN #	Are they an existing patient?	Yes	No
		☐	☐			☐	☐

Child/Dependent

Last Name	First Name	Mid. Initial	Birth Date (mm/dd/yyyy)	Social Security #

Mailing Address (if different)	Unit #	City	State	Zip Code	Are they a full time student?	Yes	No
						☐	☐

Biological Child	Adopted Child	Stepchild	Legal Guardianship	Male	Female	Nonbinary	Medical	Dental	Flex Spend
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PCP/IPA Name & PCP/IPA #	Are they an existing patient?	Yes	No	OB/GYN Name &OB/GYN #	Are they an existing patient?	Yes	No
		☐	☐			☐	☐