



# Return this completed form to Human Resources within 1 week

## Open Enrollment—Benefit Election & Waiver Form

Company Name Resource 1, Inc. Address \_\_\_\_\_

Employee Name \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
(Please Print)

Telephone Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Please complete this election form for your 2020-2021 medical benefits in its entirety. Once the section above is filled out, please indicate:

- 1) If you are waiving coverage:** Fill out the top section of the form and check the box for "I choose to waive medical coverage for myself and my dependents." Then print your name, sign and date the bottom of the form, and email it to Marcy Link in Human Resources at [mmlink@resource1.com](mailto:mmlink@resource1.com) within 1 week.
- 2) If you are electing coverage:** Fill out the top section of the form, select plan option and tier, and add dependents if applicable. Then print your name, sign and date the bottom of the form, and email it to Marcy Link in Human Resources at [mmlink@resource1.com](mailto:mmlink@resource1.com) within 1 week.

### Medical Coverage I choose to waive medical coverage for myself and my dependents BlueCross BlueShield of IL

Election	PPO - MPPE3Q26	HSA - MPPO1Q07
Employee Only	<input type="checkbox"/> \$1,160.51 monthly	<input type="checkbox"/> \$943.32 monthly
Employee + Spouse	<input type="checkbox"/> \$2,128.05 monthly	<input type="checkbox"/> \$1,729.79 monthly
Employee + Child(ren)	<input type="checkbox"/> \$2,069.44 monthly	<input type="checkbox"/> \$1,682.18 monthly
Family	<input type="checkbox"/> \$3,036.98 monthly	<input type="checkbox"/> \$2,468.65 monthly

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

### Dependent Information — Must be completed if you have any dependents to be enrolled in the medical insurance.

Name	Relationship	Medical
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

### Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes to your medical insurance will be during the HSA special open enrollment (see HR for details), or at next year's open enrollment period for a 11/1/2021 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 your local Human Resources representative within 30 days of the life status change.

**My signature below authorizes Resource 1, Inc. to deduct insurance premiums on a pre-tax basis.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_