2026 Open Enrollment Form
Retirees

CONFIDENTIAL INFORMATION

THE VILLAGE OF OAK LAWN

SECTION 1 – Personal Information & Elections

Personal Information

Last Name, First Name, Middle Initial	Gender	Social Security Number	Email Address (please complete)
Address		Preferred Phone Number	Date of Birth
City	State	Zip Code	Date of Hire

Plan	Carriers Effective January 1, 2026	Plan Year 2026 Benefit Elections

☐ ***I would like to keep all my benefits the same for 2026. (If you are on the Buyout Plan currently and wish to remain so, please complete and return the 2026 Buyout form. If you are in the PPO plan currently, you will be changed to the BCO PPO plan.) Proceed to Section 4 on next page.***

☐ ***I would like to make changes to my benefits for 2026. Please Complete Sections 2, 3 and 4:***

Section 2 - Plan Selection

Medical &, Prescription Drugs	**Waive Coverage**	☐ I am waiving my Medical Coverage for 2026 (Please complete Medical Buyout Form. Per CBA only)
	BCBS IL Blue Advantage HMO (Base Plan)	**HMO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family **Employee PCP and Medical IPA Number:** _____
	BCBS IL HMO Illinois	**HMO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family **Employee PCP and Medical IPA Number:** _____
	BCBS IL BCO PPO	**PPO Plan** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Dental	**Delta Dental**	**Dental PPO** *(only available as a Cobra benefit for up to 18 months after separation of employment)* ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Waive Coverage
Vision	**Eye Med Vision**	**Vision PPO** *(only available as a Cobra benefit for up to 18 months after separation of employment)* ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Waive Coverage

SECTION 3 – Dependent Enrollment (Medical, Dental and Vision)

I elect to enroll my dependents listed below. Dependent shall mean any of the following: (a) The employee's lawful spouse recognized by the federal government; or (b) eligible employee's natural or adopted children including children placed with the employee for the purpose of adoption or legal guardianship; or (c) step children, living in a parent-child relationship with the employee, who; is a dependent of the employee, resides in the same country as the covered employee, and is under 26 years old or (d) is mentally or physically disabled in accordance with the handicapped children's provision.

Dependent Name	Gender	Date of Birth	Relationship	Social Security # (Required if adding dependent to coverage)	Primary Care Physician (PCP #) & Medical Group IPA # (Required if electing HMO Plan for dependents)

SECTION 4 – Acknowledgement and Authorization

1. I agree that my enrolled family and I shall abide by the provision of coverage in the service agreement of the Plan under which we are enrolled. The Plan document will determine the rights and responsibilities of member(s) and will govern in the event of a conflict with any benefits comparison or summary.
2. I hereby authorize any provider, insurance company, or organization to release any information regarding treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with these Plans.
3. I understand my premiums payment for medical, dental and vision must be submitted by the first of each month by personal check, online payment or payment through pension plan deductions.
4. I certify that the foregoing information is true and correct.

_____ _____ _____

Employee Printed Name | Employee Signature | Date