Illinois Wesleyan University

Employee Benefits Election Form

Sign and return to < s] Œ](309) 556-3971
l i] Œ] v@iwu.edu), Human Resources Department

Health Insurance:

BCBSIL Health Plan Options (check only one):

Signature of Employee to ENROLL:

_____

Date:_____

Dependent Information:

Are you or any of your dependents covered by another group medical plan? Circle one: Yes No
If yes, effective date of coverage:_____
Name of Primary Insured/Policy Holder:_____ DOB: _____
Name of covered dependent(s): _____
ID No.:_____ Name of Insurance Carrier or TPA: