SWCD PERSONNEL STATUS FORM

✸ *To be completed by **ALL** newly employed or departing employees* ✸

Name: _____ **Position/Title:** _____

County: _____ **E-Mail Address:** _____

BLWR Region:_____ **NRCS FOD:**_____ **SWCD City Location:** _____

Check One: ☐ New SWCD Employee **Date Started:** _____

☐ Departing Employee **Date Departed:** _____

☐ Transferred **New location:** _____

☐ Name Change **From:** _____ **To:** _____

☐ Hours Change **Hours worked:** _____**/week** **OR** _____**/year**

SWCD OF ILLINOIS INSURANCE QUALIFICATION

Check one of the following:

☐ Qualifies – employee works 50% or more of the regular work week hours

☐ Does not qualify – employee works less than 50% of the regular work week hours

☐ Does not qualify – employee works in a temporary position

1. I, _____ , have read and understand the qualifications for the SWCD of Illinois Health Insurance Plan and that as an employee working 30 hours or more per week, that this insurance is an optional benefit.

2. As a permanent full-time employee I ☐ **Do** ☐ **Do Not** wish to participate in the Group Health Plan. I understand that later application for insurance may limit my access to complete coverages. I understand that if I agree to participate that my coverage will become effective on the first day of the month following a 60 day waiting period.

3. As a permanent full-time employee I ☐ **Do** ☐ **Do Not** wish to participate in the Life/Long Term Disability insurance program and that later application for this insurance may limit my access to additional coverages and may require additional medical history information.

4. As a permanent full-time employee I ☐ **Do** ☐ **Do Not** wish to participate in the Short Term Disability insurance program and that later application for this insurance may limit my access to coverage and may require additional medical history information.

5. As a permanent full-time employee I ☐ **Do** ☐ **Do Not** wish to participate in the Voluntary Family Vision insurance program.

My ☐ completed application **or** ☐ waiver was submitted today to _____ County SWCD.

_____ _____

Employee Signature *Date* *SWCD Chair Signature* *Date*

QUALIFICATION FOR INSURANCE CONTINUATION

To be completed by all insured departing employees.

I, _____ have submitted my resignation effective _____

My current mailing address is: _____

_____

VERIFICATION OF COMPLETION & SUBMITTAL OF FORMS

Form was completed on_____ by_____ Title: _____
This form was completed and sent with completed health and life insurance forms or a waiver of insurance form to the Administering County on_____.

Please distribute copies to:

☐ **Administering County:** Montgomery County SWCD, 1621 Vandalia Rd, Hillsboro, IL 62049
* Include: *Copy of status form, waiver for or new enrollment health & life forms*

☐ **IDOA/BLWR:** Attn: Mathew.b.gleckler@illinois.gov

☐ **AISWCD:** grant.hammer@aiswcd.org

☐ **NRCS:** Attn: Area Admin Coordinator

☐ **Regional Representative:**

Marty McManus, Region 1
Joe Bybee, Region 2
Elliott Lagacy, Region 3
Gary Albers, Region 4