SWCD PERSONNEL STATUS FORM

✷ *To be completed by **ALL** newly employed or departing employees & other status changes* ✷

Name: ______________________________ **Position/Title:** ______________________

County: ______________________________ **E-Mail Address:** ______________________

BLWR Region ____ **NRCS FOD**_____ **LUC No.** ____ **SWCD City Location:** __________________

Check the box that describes the status of this employee and complete the corresponding information:

- ☐ New SWCD Employee ....Date Started: ______________________________
- ☐ Departing Employee.............................Date Departed: ______________________________
- ☐ Transferred ....New location: ______________________________
- ☐ Name Change ....From: __________________ To: __________________
- ☐ Hours Change......................................New Hours worked: ________ /week OR ________ /year

SWCD OF ILLINOIS INSURANCE QUALIFICATION

For all statuses other than Departing Employee, check one of the boxes below, complete 1-6, sign & date:

- ☐ 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, 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.

6. 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 ______________. In order to receive the required notification about continuing insurance benefits under COBRA, I am providing my contact information.

My current mailing address is: ____

My personal email address is: ____

VERIFICATION OF COMPLETION & SUBMITTAL OF FORMS

Form was completed on ________________ by ______________________ whose title is _________________________.

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
melissa.cauble@il.nacdnet.net

* *For new employees or newly insurance-eligible employees, include a copy of this status form* ***plus*** *either a waiver for health/life insurance* ***or*** *new health & life enrollment forms*

☐ **AISWCD:** ashley.curran@aiswcd.org

☐ **NRCS:** Employee's corresponding Area Admin Coordinator:

NRCS Area 1: Allison Ocepek @ Allison.Ocepek@usda.gov
NRCS Area 2: Lesley Grayson @ Lesley.Grayson@usda.gov
NRCS Area 3: Karla Altemeyer @ Karla.Altemeyer@usda.gov
NRCS Area 4: Katie Vordtriede @ Katie.Vordtriede@usda.gov

☐ **IDOA:** Employee's corresponding IDOA Regional Representative:

IDOA Region 1: Marty McManus @ Marty.Mcmanus@illinois.gov
IDOA Region 2: Shelly Ray @ Shelly.L.Ray@illinois.gov
IDOA Region 3: Elliot Lagacy @ Elliot.Lagacy@illinois.gov
IDOA Region 4: Debbie Gray @ Deborah.Gray@illinois.gov
IDOA Region 5: Nikki Moore @ Nikki.Moore@illinois.gov