City of Boulder Life Event Benefits Change Form

Please return completed/signed form to HR
HRBenefits@bouldercolorado.gov

Eff. Date: _____
HR Use Only
SMBO _____ **Munis** _____

EMPLOYEE INFORMATION

Printed Name:_____
(First) (Middle Initial) (Last)

Emp ID#: _____

LIFE EVENT ACTIONS

The City of Boulder plans allow for changes outside of annual open enrollment only when an event creates a special open enrollment period. The change must be allowable under the Internal Revenue Code and correspond to and be consistent with the special life event. (Speak with Human Resources to know what corresponds to your event.) You are required to provide proof of the event that creates the special period allowing changes. You must submit this form and proof of the event no later than 30 days after the event. More details on life mid-year plan changes can be found in the benefits guide.

Provide Date of Event: _____		*Attach relationship and/or event documentation*
ENROLL/CHANGE due to event:	**CANCEL** due to event:	Comments:
☐ Birth/Adoption ☐ Marriage ☐ Domestic Partnership/Civil Union ☐ Court Order ☐ Involuntary Loss of Coverage ☐ Return from Leave ☐ Change in Employment Status ☐ Change in Dependent Care Cost ☐ Other (explain in comments box)	☐ Unpaid Leave of Absence ☐ Divorce/Legal Separation ☐ Termination of Partnership/Union ☐ Death of a Dependent ☐ Child over age 26 ☐ Family Member ☐ Other (explain in comments box)	

Name Change **Bring your new social security card to Human Resources front desk for confirmation and copying*

Current Name: _____
(First) (Middle Initial) (Last)

New Name: * _____
(First) (Middle Initial) (Last)

CHOOSE PLAN TO ADD OR REMOVE THE FOLLOWING DEPENDENTS TO/FROM MY COVERAGE

	CIGNA HEALTHCARE	DELTA DENTAL	VISION SERVICE PLAN
Plan:	☐ $1,250 Deductible Open Access Plan ☐ $2,000 Deductible and HSA-Eligible Open ☐ Waive Medical Coverage	☐ Delta Premier (High Plan) ☐ Delta Preferred (Low Plan) ☐ Waive Dental Coverage	☐ Enroll-Base ☐ Enroll-Buy Up ☐ Waive Vision Coverage
Tier:	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family

City of Boulder Life Event Benefits Change Form

Please return completed/signed form to HR
HRBenefits@bouldercolorado.gov

Use* A to Add *and* R to Remove *the following Dependents to/from my coverage:

A/R	Dependent's Name (First, MI, Last)	Relationship*	Dependent's Social Security # ***Required***	Male Or Female	Date of Birth (MM/DD/YYYY) ***Required***	Disabled (Y/N)	Add to Medical (Y/N)	Add to Dental (Y/N)	Add to Vision (Y/N)

Note: Allowable relationships include spouse, domestic partner, civil union partner, birth child, adopted child, child for whom you have legal guardianship, disabled child over the age of 26, partner's child for whom you are responsible (dependent per the IRS guidelines), step child, any other person you have been granted legal guardianship for through the courts. Proof of eligibility may be required.

Health Care Flexible Spending Account (HC FSA)

Available to all benefits eligible employees who are not participating in an HSA account. Eligible expenses must be incurred between January 1 and March 15 of the following year. Any monies remaining in the account as of March 31 are forfeited. Enrolling requires a supplemental form.

☐ Enroll/Change ☐ Waive	*What amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *$*_____ *(minimum $120, maximum $2,750)*

Dependent Care Flexible Spending Account (DC FSA) (Day Care)

Available to all benefits eligible employees. Eligible expenses must be incurred between January 1 and March 15 of the following year. Any monies remaining in the account as of March 31 are forfeited. Enroll, requires a supplemental form.

☐ Enroll/Change ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *$*_____ *(minimum $120, maximum $5,000)*

Health Savings Account (HSA) **Enrollment**

Available to all employees who elect the $2,000 high deductible health plan. Eligible expenses must be incurred after the creation of the account. Any monies remaining in the account at the end of the year are retained by the employee. Employees age 55 or older may contribute an additional $1,000. **If you are going from Family to Single or Single to Family please contact your financial institution for IRS limits.** * Please also complete the HSA Enrollment Form.

☐ Enroll ☐ *55+ Catch up* ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction each pay period?*	Per Pay Period Election Amount *$*_____

HSA Changes:	**HSA Changes**:
☐ Cancel contributions ☐ Increase or Decrease contributions New **dollar amount** per pay check: $_____	Apply the change for: ☐ The remainder of the payroll year ☐ A set number of pay checks: _____

City of Boulder Life Event Benefits Change Form

Please return completed/signed form to HR
HRBenefits@bouldercolorado.gov

Supplemental Retirement Savings	
457 plan administered by ICMA	**401(k)** plan administered by PERA
☐ Enroll, requires a supplemental form ☐ ☐ Cancel contributions Increase or Decrease contributions ☐ *50+ Catch up* New Pre-tax: _____% or $_____ New Post-tax (ROTH): ____n/a____% - $_____	☐ Enroll, requires a supplemental form ☐ ☐ Cancel Contributions Increase or Decrease contributions ☐ *50+ Catch up* New Pre-tax: _____% or $_____ New Post-tax (ROTH): ____n/a____% - $_____

Alfac	
☐ Enroll ☐ Waive	
LegalShield Plan	**IDShield**
☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Pets Best – Begin enrollment at petsbest.com/COBPETS – Discount code COBPETS	

Signature for Insurance Carriers

I confirm that the information I have provided on this form is complete and accurate.

I understand that the benefit plans that I have selected provide reimbursement for certain costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or expenses which I have incurred may not be covered by my benefit plan.

I understand that the terms of the contract between the insurance carrier and my employer may not allow late enrollment for me and my dependents.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention products or services that might be valuable to me and otherwise as permitted by law. I understand that my information on benefits may be combined in aggregate at the carrier level with other member's information so that it is no longer individually identifiable and can be used for commercial and other purposes.

I authorize payroll deduction of any applicable employee premiums for these benefits.

Signature: _____ Date: _____

Employees working in standard positions but working less than 20 hours per week are not eligible to participate in any of the above insurance plans.