City of Boulder Mid-Year Benefits Change Form

Please return completed/signed form to HR

HRBenefitsForms@bouldercolorado.gov
3065 Center Green Drive
Boulder, CO 80301

Eff. Date: _____

Emp ID#: _____

HR Use Only
Munis _____

EMPLOYEE INFORMATION

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

Social Security Number: _____-_____-_____

MID-YEAR ACTIONS

The changes listed below are allowable at any time during the year and do not require a special life event.

CHANGE – Any Time	
☐ Name	☐ Life Insurance
☐ Address/Phone	☐ Life Insurance. Beneficiary Change
☐ Health Savings Account (HSA)	☐ Disability Insurance
☐ Retirement Savings	☐ Other (please explain in comments box)
Comments:	

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)

Address/Phone Change: (*New Information)*

Street Address_____ City_____ State _____ Zip _____

Home Phone: _____ Mobile Phone: _____

Health Savings Account (HSA)

☐ Enroll, please complete the H.S.A. enrollment form	☐ ONE TIME contribution (*one pay period*)	☐ I would like to make multiple contributions for a specific range of time. (*several checks*)
☐ Cancel contributions	One-time Amount of:	Amount of: $_____
☐ Increase or Decrease contributions	$_____	beginning Pay Period: _____
New **dollar amount** per pay check:	during Pay Period*	ending Pay Period: _____
$_____	_____.	After this period ends, I would like to contribute $_____ per Pay Period
	After the one-time contribution, I would like to contribute $_____ per pay period	

***** To make changes for a *specified* pay period, this form must be submitted by the same date personnel action forms are due for that pay period. For the current payroll calendar, please visit the Human Resources intraweb page.

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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 New Pre-tax: _____% or $_____ New Post-tax (ROTH): ____n/a____% - $_____	☐ Enroll, requires a supplemental form ☐ Cancel Contributions ☐ Increase or Decrease contributions New Pre-tax: _____% or $_____ New Post-tax (ROTH): ____n/a____% - $_____

Additional Life and Accidental Death & Dismemberment Coverage

☐ Enroll/Increase Amount ☐ Cancel ☐ Update Beneficiaries *Review the plan certificate for details on coverage amounts at various ages and for benefits for dismemberment.	Additional Life purchased through payroll deduction: Mid-Year requests to increase coverage require a supplemental form for medical underwriting approval. You may elect spouse coverage up to 100% of the amount requested for the employee.	Additional Life purchased through payroll deduction: You may elect up to $10,000 on your children. The entire amount is guaranteed issue. The cost is the same, no matter the number of children you have. Employee also must elect voluntary life for an amount equal to or greater than dependent voluntary life.

Beneficiary Designation: The employee is automatically the beneficiary on Spouse and Child coverage amounts. Please complete the life insurance beneficiary form to designate and/or change your beneficiaries. **Note:** A beneficiary can be a person, an estate, a trust or an organization.

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.