City of Boulder Cobra/Retiree 2018 Open Enrollment/Change Form

Please return the completed/signed forms to HR/Benefits
3065 Center Green Drive
Boulder CO 80301

EMPLOYEE INFORMATION

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

Street Address_____ City_____ State _____Zip _____

Date of Hire: _____/_____/_____
(MM) (DD) (YYYY)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Civil Union ☐ Divorced ☐ Widowed

Gender: ☐ M ☐ F Date of Birth: _____/_____/_____(**required** by insurance carriers)
(MM) (DD) (YYYY)

SS#: _____ - _____ - _____ (**required** by insurance carriers)

Home Phone: _____ Mobile Phone: _____

ENROLLMENT SELECTION

	CIGNA HEALTHCARE	DELTA DENTAL**	VISION SERVICE PLAN **
Plan:	☐ $500 Deductible Open Access Plan ☐ $1,000 Deductible Open Access Plan ☐ $1,500 Deductible Open Access-HSA Eligible ☐ $5,000 Deductible Open Access-HSA Eligible ☐ Waive Medical Coverage	☐ Delta Premier (High Plan) ☐ Delta Preferred (Low Plan) ☐ Waive Dental Coverage **No new enrollments beyond initial 18 months	☐ Base ☐ Buy Up ☐ Waive Vision Coverage **No new enrollments beyond initial 18 months
Tier:	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family

Remove/Add the following Dependents to my coverage:

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)	Enroll Medical (Y/N)	Enroll Dental (Y/N)	Enroll 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.

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Signature for Insurance Carriers

- ☐ I certify that I have been given the opportunity to enroll for group insurance benefits as offered by and through the City of Boulder. I also certify that by completing this enrollment, I agree to abide by the eligibility, enrollment and election procedures for my City of Boulder benefits.

- ☐ I acknowledge that participating providers are not agents or employees of the City and provider participation may change.

- ☐ I agree to utilize the appeal procedure(s) established by the carrier(s) for resolving claims disputes. Depending on the conditions set forth by the carrier, this agreement may require binding arbitration instead of a court trial for dispute resolution.

- ☐ I acknowledge that carriers may release certain information about me and/or my dependent(s) when required under federal or state law, or pursuant to legal process, and may release and obtain medical information to or from other carriers, providers, and public agencies for the purpose of providing health care services, to facilitate payment for these services, and to conduct related administrative operations.

- ☐ I hereby apply for the above listed coverage for myself and eligible family dependents listed in this enrollment. I understand that if I/we are accepted for coverage, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

Signature: _____ Date: _____