City of Boulder Cobra/Retiree Life Event Benefits Change Form

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

EMPLOYEE INFORMATION

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

Street Address_____ City_____ State _____Zip _____

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: _____

MID-YEAR 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 31 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 ☐ Involuntary Loss of Coverage ☐ Change in Employment Status ☐ Other (explain in comments box)	☐ Divorce/Legal Separation ☐ Termination of Partnership/Union ☐ Death of a Dependent ☐ Child over age 26 ☐ Other (explain in comments box)	

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

	CIGNA HEALTHCARE	DELTA DENTAL	VISION SERVICE PLAN
Plan:	☐ $500 Deductible Open Access Plan ☐ $1,000 Deductible Open Access Plan ☐ $1,500 Deductible and HSA-Eligible Open Access ☐ $5,000 Deductible and HSA-Eligible Open Access ☐ 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

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Use* A to Add *and* R to Remove *the following Dependents to/from my current 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.

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: _____