Eff. Date: _____

Eff. Pay Period: _____

Employee ID#: _____

City of Boulder Seasonal/Temporary Employee Medical Enrollment Form

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

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 (*provide relationship documentation to enroll dependents)*

Gender: ☐ M ☐ F Date of Birth: _____/_____/_____ (MM/DD/YYYY)

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

Home Phone: _____ Mobile Phone: _____

ENROLLMENT SELECTION

	CIGNA HEALTHCARE
Plan:	☐ $1,000 Deductible Open Access ☐ $1,500 Deductible Open Access/HSA-Eligible ☐ $5,000 Deductible Open Access/HSA-Eligible ☐ Waive Medical Coverage
Tier:	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family

Add the following Dependents to my coverage:

Dependent's Name (First, MI, Last)	Relationship	Dependent's Social Security #	Gender	Date of Birth (MM/DD/YYYY)	Disabled? (Y/N)	Add to Medical? (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, step child, any other person you have been granted legal guardianship for through the courts.

Supplemental Retirement Savings (Voluntary)	
401(k) plan administered by PERA	457 plan administered by ICMA
☐ Enroll, requires a supplemental form ☐ Waive	☐ Enroll, requires a supplemental form ☐ Waive
Alfac	
☐ Enroll, requires a supplemental form ☐ Waive	

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.

Date: _____ Signature: _____