**TYPE OF ENROLLMENT**

**Open Enrollment**

**Effective Date of Coverage:**

**07/01/2020**

07/01/2020

**Benefits Enrollment Form**

1. **Employee Data** (please print legibly) [ ] Change in address

**NAME (LAST, FIRST, M.I.) LAST FOUR OF SSN DATE OF BIRTH**

**ADDRESS STREET CITY STATE ZIP CODE**

**HOME PHONE WORK PHONE SEX (M/F/X)**

1. **Deadline Information**

If you have questions or need assistance with this form contact your agency Benefits Administrator. **This form must be completed in its entirety.**

This form is to be used by employees who do not have access to the benefits system from April 14, 2020 to May 18, 2020. You must submit this form to your agency Benefits Administrator prior to May 18. Any mail-in forms must be post-marked on or before May 18, 2020.

Supporting Dependent Eligibility Verification documentation must be submitted to your agency Benefits Administrator before June 12, 2020. Any mail-in Dependent Eligibility Verification documentation must be post-marked on or before June 12, 2020.A list of acceptable Dependent Eligibility Verification documents are on Page 4 of this enrollment form.

Your elections are irrevocable and cannot be changed during the plan year, except as provided in the State of Colorado Salary Reduction Plan document.

1. **Health Plan**
2. **Choose your Health Plan Option:**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Cigna Copay Basic | □ Cigna Copay Plus | □ Cigna HDHP | □ Waive coverage |
| □ Kaiser Copay Basic | □ Kaiser Copay Plus | □ Kaiser HDHP |  |

1. **Choose your Level of Coverage:**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Employee only | □ Employee plus child(ren) | □ Employee plus spouse | □ Family |

1. **Tobacco Surcharge** (This question applies to employees only. It does not apply to other people covered on your plan)

The State is committed to helping you achieve your best health. You, the employee, will pay a lower cost for coverage if you do not use tobacco products. If you, the employee, are a tobacco user, but agree to complete a no-cost tobacco cessation program then you will qualify to receive the same rates as a non-tobacco user. Tobacco use includes any form of tobacco/nicotine product. Including products that are smoked, sniffed, sucked, or chewed. Vaporizers, e-cigarettes and other electronic nicotine delivery systems are also considered tobacco products. The tobacco cessation program includes coaching and free nicotine replacement products. Employees with either Kaiser Permanente or Cigna may enroll in the program by calling 1-800-CIGNA24.

*Please remember that any person who knowingly, and with intent to defraud any insurance company, or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. Penalties may include imprisonment, fines, denial of insurance, and civil damages.*

□ Although I have used tobacco products in the last six months I will not participate in a smoking cessation program. I understand that my premium will increase by $75.

□ I have not used tobacco products in the last six months/ I used tobacco products in the last six months and will complete a no-cost cessation program.

1. **Choose your premium deduction**

□ Pre-tax □ Post-tax

1. **Health Saving Account Option** (For employee enrolled in Cigna or Kaiser HDHP)(Pre-tax)
2. **Choose your HSA election**

□ Health Saving Account, please elect your contribution amount for the Health Savings Account.

I elect to contribute $ per year to my Health Savings Account through Optum Bank (not to exceed IRS limits).

I understand that I cannot participate in both a Health Savings Account and a General Purpose Health Care Flexible Spending Account. I understand I must open or have an existing Optum Bank account that is associated with the State of Colorado.

□ Waive option

1. **Dental Health Plan**
2. **Choose your Dental Plan Option:**

|  |  |  |
| --- | --- | --- |
| □ Delta Dental Basic | □ Delta Dental Basic Plus | □ Waive coverage |

1. **Choose your Level of Coverage:**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Employee only | □ Employee plus child(ren) | □ Employee plus spouse | □ Family |

1. **Choose your premium deduction**

□ Pre-tax □ Post-tax

1. **Vision Plan** (For employees who enroll in a medical plan).

Basic Vision is included with medical coverage.

1. **Choose your Vision Plan Option:**

□ Enhanced Vision Plan buy-up option

□ Waive coverage

1. **Health and Dental Plan Information** (Please print. Be sure to check the appropriate boxes for the coverages you elect for your dependents; you may add any additional dependents on a separate sheet of paper.)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME**  **(LAST IF DIFFERENT, FIRST, M.I.)** | **RELATIONSHIP** | **DATE OF BIRTH (MM/DD/YY)** | **SEX (M/F/X)** | **SOCIAL SECURITY NUMBER** | **HEALTH** | **DENTAL** | **CHILD LIFE** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Optional Life Insurance** (after-tax)

□ Enter Employee Optional Life Amount: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ Waive Coverage

Optional Life Insurance is in addition to the Basic Life Insurance (one times your annual base salary) that the State of Colorado provides at no cost to you.

Optional Life coverage is available from $0 - $500,000 in increments of $10,000, subject to medical underwriting if increasing current coverage amount.

1. **Optional Spouse Life Insurance** (after-tax)

□ Enter Optional Spouse Life Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Waive coverage

Optional Spouse Life Insurance Optional Life coverage is available from $0 - $250,000 in increments of $10,000 (not to exceed 50% of the employee’s voluntary life coverage). Subject to medical underwriting if increasing current coverage amount.

1. **Optional Child Life Insurance** (after-tax)

|  |  |  |  |
| --- | --- | --- | --- |
| □ $5000 | □ $10,000 | □ Waive coverage |  |

Optional Child Life Insurance Optional Life coverage is available in $5,000 or $10,000 (not to exceed 50% of the employee’s voluntary life coverage).

1. **Flexible Spending Accounts** (pre-tax)

Health Care Flexible Spending Account (maximum annual contribution is $2750):

□ Limited Purpose - I elect to contribute $

□ General Purpose - I elect to contribute $

□ Decline Participation - I do not wish to participate this year.

Dependent Care Flexible Spending Account (Maximum annual contribution is $5000):

□ I elect to contribute an annual amount of $

□ Decline Participation - I do not wish to participate this year.

# Signature

I certify below that I have completed this form to the best of my knowledge, and I understand the following:

* My request will be submitted for the FY2020-21 plan year. Changes will be effective 7/1/2020.
* If I have added newly eligible dependents to my plan(s) I will need to submit dependent verification documentation. A list acceptable documentation is on page 4. If documentation is not received by June 12, 2020 the coverage I have elected for my newly eligible dependent will be removed.
* My coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying life event as defined by the Salary Reduction Plan; I may, however, change my coverage elections during the next open enrollment period.
* I agree to the cost of the premiums, and my pay will be reduced by the amount of any required contributions noted for the coverages elected where the contributions are pre-tax.

I understand the benefits and agree to the provisions as described in the Plan document(s).

**SIGNATURE DATE**

**Please return this Open Enrollment Form to your agency Benefits Administrator:**

**[Benefits Administrator Name]**

**[Street Address]**

**[City, State, Zip]**

**[Phone Number]**

**[Fax Number]**

**[Email Address]**

**List of Acceptable Documentation for Dependent Eligibility Verification**

Spouse:

* Registered Marriage certificate

Civil Union Partnership:

* A copy of the Civil Union Certificate received from the County Clerk and Recorder or a record of the Civil Union received from the State Registrar as presumptive evidence of the Civil Union.

Common-Law Spouse:

* Common-law affidavit

AND

* A document dated within the last 60 days showing current relationship status, such as a joint household bill or joint bank/credit account, etc. The documents must be dated and list your partner’s name at your mailing address.

Children:

* A copy of the child’s registered birth certificate or adoption certificate, naming you or your spouse/SGDP/Civil Union Partner as the child’s parent

OR

* Appropriate custody or allocation of parental responsibility naming you or your spouse/SGDP or Civil Union Partner as the responsible party to provide insurance for the child.

\*\*\*\*\* NOTE: If this is the child of the Common Law Spouse, a Civil Union Partner, a step parent or a Same Gender Domestic Partner, please note that the relationship between the two adults must also be established and verified even if you are not covering them on any of your benefits.\*\*\*\*\*