BENEFIT ENROLLMENT FORM

PERSONAL INFORMATION

EMPLOYEE NAME (AS IT APPPEARS ON SOCIAL SECURITY CARD)	DOB	SOCIAL SECURITY NO.	EMPL ID #	HIRE DATE

Note on Health Credits: Distrcit Medical Credit applied on rates below. Additional flex credit of up to $70 per paycheck for employees working 30 hours or more per week. Any unused credits are forfeited.

***SUPPORTING DOCUMENTATION OF THE QUALIFYING EVENT MUST BE SUBMITTED WITH THIS FORM ***

Include the date of the qualifying event. If adding a dependent and/or spouse due to COVID 19, indicate COVID19 in the explanation

MARRIAGE	BIRTH	ADOPTION	DIVORCE	OTHER/EXPLANATION

Effective Date:

Group Health Insurance Plan (GHIP) *Eligible* for State Share

Coverage Level	EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
Highmark Delaware BCBS First State Basic Plan	◯ $0.00	◯ $0.00	◯ $0.00	◯ $0.00
Aetna CDH Gold Plan	◯ $0.00	◯ $0.00	◯ $0.00	◯ $0.00
Aetna HMO Plan	◯ $0.00	◯ $9.99	◯ $0.00	◯ $1.03
Highmark Delaware BCBS Comprehensive PPO Plan	◯ $28.41	◯ $74.53	◯ $45.93	◯ $81.84
	◯ WAIVE			

Effective Date:

Cigna Dental Insurance

Coverage Level		EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
	◯ WAIVE	◯ $36.13	◯ $51.06	◯ $64.64	◯ $70.76

VBA Vision Insurance

Coverage Level		EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
	◯ WAIVE	◯ $5.22	◯ $9.91	◯ $9.25	◯ $13.81

IMPORTANT NOTICE REGARDING SPOUSAL COORDINATION OF BENEFITS (SCOB)

If you have selected either an "Employee & Spouse or "Family" level for your health care benefit on page one of this form, you **MUST** complete the electronic Spousal Coordination of Benefits Form upon initial enrollment, anytime enrollment or insurance status changes and each year during Open Enrollment.

SCOB POLICY: The Spousal Coordination of Benefits Policy can be found at:

https://dhr.delaware.gov/benefits/cob/education.shtml

(AS IT APPEARS ON SOCIAL SECURITY CARD) SPOUSE'S NAME	SOCIAL SECURITY NO.	DOB	GENDER

Does your spouse work for a State of Delaware agency? ◯ **YES** ◯ **NO**

Dependent Information

(AS IT APPEARS ON SOCIAL SECURITY CARD) DEPENDENT NAME	DOB	SOCIAL SECURITY NO.	GENDER	RELATIONSHIP	PCP ID# (For Aetna HMO ONLY)

CERTIFICATION EMPLOYEE MUST SIGN AND DATE

By my signature below, I herby certify the benefit elections made on this form are my choice and I have completed the required forms necessary to enroll in the benefit elections chosen. I understand that, by completing and signing the required forms, I am making a binding election with regard to my benefits for the current plan year and unless I have a permissible family status changes as defined by the Internal Revenue Service, or I terminate employment with the State of Delaware .

SIGNATURE

DATE

COMPLETING THIS FORM FOR A QUALIFYING EVENT

Medical Insurance

To enroll/waive spouse, children or other dependents, check the box for the coverage level desired. Please note, a change in plan your carrier is not permissable under a qualifying event. If you need to change your plan carrier, please contact your benefits office. You may also change plan carriers during open enrollment each year.

Dental and Vision Insurance

To enroll/waive spouse, children or other dependents, check the box for the desired coverage level. If no changes will be made, check the box for your current coverage level. To waive covergae check the WAIVE box.

Employer Information for Spouse

This section is required for enrolling a spouse under a qualifying event.

If you are enrolling your spouse, indicate if your spouse is an active employee for the State of Delaware. List the agency/department for your spouse's employer, and your spouse's date of birth as MMDDYYYY format.

Dependent Information

This section is required to be completed for enrolling children or other qualified dependents.

All fields are required. List all dependent information for spouse, children, step children, adoptive children, dependent children or any qualified dependent you plan to enroll in medical, dental and vision benefits.

Signature and Date are required to authorize the benefits office to complete enrollment.

Benefits Worksheet

District Dental Insurance	Cost	
Employee Only	$ 36.13	
Employee and Spouse	$ 51.06	
Employee and Child(ren)	$ 64.64	
Family	$ 70.76	**Subtotal:**

District Vision Insurance	Cost	
Employee Only	$ 5.22	
Employee and Spouse	$ 9.91	
Employee and Child(ren)	$ 9.25	
Family	$ 13.81	**Subtotal**

District Life Insurance

Calculation

Annual base salary x 1.5. Round up to the next $500 for Benefit amount.

Benefit amount x .00144 = annual premium/24 = Pay Paycheck Cost

Subtotal:

District Long Term Disability Buy Up Plan

Annual Salary X .00133 = Annual Premium/24 = Cost per Paycheck

Subtotal:

Group Health Insurance

No waiting Period

After 90 day Waiting Period

Please Note: Rates are on the health enrollment form. **Subtotal:**

Flex Credit

Flex Credits- Deduct from Subtotal

Full Time Employee- Up to $70.00

Half Time Employee- Up to $35.00

Quarter Time Employee - Up to $17.50 **Subtract Credit: ( )**

This is the amount you will pay each paycheck. **Total**