Boulder Valley School District
Excellence and Equity

CIGNA

KAISER PERMANENTE

DELTA DENTAL

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http://www.bvsd.org

INSURANCE BENEFITS ENROLLMENT/CHANGE FORM

Read all Plan Summaries before completing this form. This form is for BVSD benefit eligible employees enrolling in ***medical and / or dental*** *coverage OR making changes to their existing coverage. Please use a pen to complete each section,* ***sign the form,*** *and return it to Human Resources.*

For BVSD Use:
HR Rep ____________________
Date ____________________

Section 1: Action

☐ NEW ENROLLMENT ☐ CHANGE ☐ CANCEL ALL COVERAGE **EFFECTIVE DATE OF COVERAGE / CHANGE** *(MM/DD/CCYY)* _____/_____/______

COVERAGE OPTIONS:
1 Myself
2 Myself & my spouse OR one child
3 Myself & my children
4 Myself & my family

PLAN SELECTION: CHOOSE AN OPTION

Medical	1	2	3	4
CIGNA - STANDARD PPO	☐	☐	☐	☐
CIGNA - BASIC PPO	☐	☐	☐	☐
KAISER Plan 220	☐	☐	☐	☐

CHOOSE AN OPTION

Dental	1	2	3	4
Delta Dental - PPO	☐	☐	☐	☐

NOTE: *Late enrollees are subject to a 12-month waiting period before getting full benefits.*

CHANGING INFORMATION:
☐ Transferring to a different plan
☐ Adding a dependent/spouse
☐ Deleting a dependent/spouse

Reason for change: ____________________________

Section 2: About You

Employee Name (Last / First / MI)	Employee ID Number	Sex	Social Security No.	Position / School or Department

Employee Date of Birth *(MM/DD/CCYY)*	Home Phone	Work Phone	Date of Hire

Home Address (Street)	City	State	Zip Code

Section 3: List Dependents (Attach additional sheet for more dependent children)

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Coverage Selection	Check one
Spouse						☐ Medical ☐ Dental	☐ Add ☐ Delete
Child						☐ Medical ☐ Dental	☐ Add ☐ Delete
Child						☐ Medical ☐ Dental	☐ Add ☐ Delete
Child						☐ Medical ☐ Dental	☐ Add ☐ Delete

Section 4: Conditions for Enrollment

The information provided above is true and correct to the best of my knowledge. I authorize any health care provider, insurance company, or other organization, institution, or person that has any information regarding my benefit eligibility or claims to release such information to the claims administrator. A copy of this authorization shall be considered as effective and valid as the original. I understand that any misrepresentation on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. Employees covering dependents have premiums deducted from each monthly paycheck. This is part of the district's Section 125 plan. Pre-tax deductions for Section 125 plans are not considered salary for PERA purposes. Pre-tax deductions increase your take home pay but reduce your PERA eligible salary. Post-tax deductions reduce your take home pay but maximize your PERA eligible salary. If you are within 4 years of retirement, take time to evaluate whether or not you should participate in a Section 125 plan.

Select one and Sign:

I authorize BVSD to make pre-tax payroll deductions to pay for the medical coverage I have elected. ☐ ***Pre-Tax*** ______________________________

Employee Signature **Date**

OR

I authorize BVSD to make post-tax payroll deductions to pay for the medical coverage I have elected. ☐ ***Post-Tax*** ______________________________

Employee Signature **Date**