Benefits Enrollment Form

2018 - 2019 Plan Year

PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED.

Employee Name (Last, First, MI)		**Social Security Number**	**Date of Birth**
Work Phone and extension ( )	**Home Phone** ( )	**Address (Mailing)**	
City, State, Zip Code		**Email Address**	
Marital Status ☐Single ☐ Married	**Gender** ☐Male ☐ Female	**Date of Hire**	**Effective Date for Benefits to Begin**

Type of Enrollment (check one)	**Reason for Change**
☐Open Enrollment ☐New Hire ☐Add Dependent(s) ☐Cancel Dependent(s) ☐Common Law Marriage ☐Domestic Partner	☐Birth ☐Other Insurance ☐Divorce ☐Loss of Coverage ☐Marriage ☐Change in Student Status ☐Other_____

MEDICAL PLANS

United Healthcare Colorado Doctors Plan $1,500/$3,000 Ded (Copay Option)	United Healthcare Colorado Doctors Plan $3,000/$6,000 Ded (HSA Option High Deductible Health Plan)	United Healthcare Charter Plan $1,500/$4,500 Ded (DHMO)
☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee + Family	☐ Employee + Family	☐ Employee + Family

Employee Primary Care Physician (PCP)

Physician First & Last Name_____

ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __

DENTAL PLANS

United Healthcare Dental Value Plan 15 In-Network	United Healthcare Dental PPO Plan 30 In-Network/Non-Network
☐ Employee Only	☐ Employee Only
☐ Employee + Spouse	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ Employee + Child(ren)
☐ Employee + Family	☐ Employee + Family

Employee Signature: _____ Date: _____

Please complete the information on the next page for any dependent you wish to add to coverage.

Employee Name_____

Dependent Information

Spouse	**Last Name, First Name, MI**	**Date of Birth**	**Social Security No.**	**Sex**	**Benefit Election (Check all that apply)**
☐Enroll ☐Cancel				☐M ☐F	☐Medical ☐Dental
Primary Care Physician (PCP) First & Last Name	ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __				

Dependent 1	**Last Name, First Name, MI**	**Date of Birth**	**Social Security No.**	**Sex**	**Benefit Election (Check all that apply)**
☐Enroll ☐Cancel				☐M ☐F	☐Medical ☐Dental
Primary Care Physician (PCP) First & Last Name	ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __				

Dependent 2	**Last Name, First Name, MI**	**Date of Birth**	**Social Security No.**	**Sex**	**Benefit Election (Check all that apply)**
☐Enroll ☐Cancel				☐M ☐F	☐Medical ☐Dental
Primary Care Physician (PCP) First & Last Name	ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __				

Dependent 3	**Last Name, First Name, MI**	**Date of Birth**	**Social Security No.**	**Sex**	**Benefit Election (Check all that apply)**
☐Enroll ☐Cancel				☐M ☐F	☐Medical ☐Dental
Primary Care Physician (PCP) First & Last Name	ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __				

Dependent 4	**Last Name, First Name, MI**	**Date of Birth**	**Social Security No.**	**Sex**	**Benefit Election (Check all that apply)**
☐Enroll ☐Cancel				☐M ☐F	☐Medical ☐Dental
Primary Care Physician (PCP) First & Last Name	ID#__ __ __ __ __ __ __ __ __ __ __-__ __ __				