HUMAN RESOURCES
1 DesCombes Drive • Broomfield, CO 80020 • 303.438.6320 • www.broomfield.org

ENROLLMENT AND AUTHORIZATION FORM– HEALTH/DENTAL

☐ Initial Enrollment	☐ Open/Special Enrollment	Status Change: *Date of Qualifying Event:* _____

Reason for Change: ☐ **Marriage** ☐ **Birth/Adoption** ☐ **Divorce** ☐ **Over-age Limit** ☐ **Spouse lost coverage** ☐ **Death** ☐ **Other**

Last Name:		First Name:		MI:	
Social Security #:		Employee ID #:		Telephone:	( )
Mailing Address(Street or PO Box):					
City:		State:		Zip Code:	

WAIVER/REFUSAL OF COVERAGE

SIGN BELOW ONLY IF YOU DO NOT WANT COVERAGE FOR YOURSELF AND/OR YOUR DEPENDENTS

I have been given the opportunity to be enrolled in the group health and/or dental benefits through the City and County of Broomfield; however, I am waiving my rights to the following coverage(s) for myself and/or my eligible dependents:

☐ Health Plan *for* Myself ☐ Health Plan *for* my Dependents

☐ Dental *for* Myself ☐ Dental *for* my Dependents

I understand that if I wish to enroll myself and/or my dependents under the Plan at a later date, the effective date of coverage may be delayed per the Plan's eligibility provisions and may be subject to additional limitations on covered benefits.

Signature:		**Date:**	

PLAN(S) IN WHICH YOU ARE ENROLLING/ENROLLED:

☐ **KAISER** ☐ **MEDICAL CARE EXPENSE PLAN** Administered by Cigna ☐ **DELTA DENTAL PLAN**

Coverage/Change Effective Date:	Hire Date (Month/Day/Year):	Employee Birth Date (Mo/Day/Yr):

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married - Spouse Email: _____

Do you have dependent children? ☐ Yes ☐ No

I desire to be enrolled as indicated below for group health and/or dental coverage. (Please list yourself and any eligible dependents you want covered on or removed from each plan.) **Documentation of dependent eligibility is required.**

Name (Include last if different)	**Health**	**Dental**	**Gender**	**Birth Date Mo/Day/Yr**	**SSN #**	**Add**	**Remove**
Self	☐	☐				☐	☐
Spouse	☐	☐				☐	☐
Child	☐	☐				☐	☐
Child	☐	☐				☐	☐
Child	☐	☐				☐	☐
Child	☐	☐				☐	☐

I AGREE TO THE NECESSARY PAYROLL DEDUCTIONS, IF ANY, FOR THE COVERAGE INDICATED BELOW:

☐ **Health Plan** ☐ Employee ☐ Employee plus One ☐ Employee plus Family

☐ **Dental** ☐ Employee ☐ Employee plus One ☐ Employee plus Family

If enrolling in the Medical Care Expense Plan, I acknowledge that I have received a copy of the Notice of Privacy Practices Regarding Protected Health Information for the Employees' Medical Care Expense Plan (Notice) and Broomfield's HIPAA Privacy Policy (Policy). By signing this form I am agreeing to receive the Notice and Policy by electronic transmission. I understand that I may request a paper copy of the Notice and/or the Policy.

MEDICARE COVERAGE – Complete this section if you, your spouse or dependent child(ren) have Medicare.

Member's Name:	Part A Effective Date:	Part B Effective Date:	Reason for Medicare: ☐Over 65 ☐ Disability ☐ Kidney Disease	Medicare Claim #::

I elect to pay my Health and/or Dental premiums on the following basis:

Health - ☐ Before Tax or ☐ After Tax

Dental - ☐ Before Tax or ☐ After Tax

By electing to have my premium(s) deducted from my pay pre-tax, I agree to the terms and conditions of the flexible spending plan (Section 125 of the IRS Code). I understand that the election is irrevocable for the plan year unless I experience a qualifying event that results in a change of status which affects eligibility, as described in the City and County of Broomfield's Cafeteria Plan Summary. I understand that this election will continue on through the new plan year unless I notify Human Resources in writing during open enrollment.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signature:		**Date:**	

For HR Use Only:

Effective		Input date		Initials	

Form #10222014