☐ New Subscriber
☐ Open Enrollment
☐ Change of Status

Colorado College

HEALTH BENEFITS ENROLLMENT FORM

Coverage Effective Date: _____

NAME (LAST, FIRST, M. I.)		SOCIAL SECURITY NO. – –	DATE OF BIRTH / /
ADDRESS		CITY	STATE / ZIP
EMPLOYMENT DATE / /	SEX ☐ Male ☐ Female	HOME PHONE NUMBER ( ) –	

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Common Law ☐ Domestic Partner

Change of Status is requested for the following reason(s): ☐ Marriage ☐ Birth/Adoption of Child ☐ Divorce/Legal Separation

☐ Custody Change ☐ Ineligible Dependent ☐ Employee/Spouse Employment Change ☐ Employee/Spouse Benefits Change

☐ Death of Spouse/Dependent ☐ Other: _____ Date of Event: _____

MEDICAL PLAN

☐ Elect Coverage
☐ Waive Coverage
☐ I have coverage elsewhere
☐ If dropping coverage, confirm health coverage will be obtained elsewhere

Coverage Level:
☐ Employee Only
☐ Employee + Spouse/Partner
☐ Employee + Child(ren)
☐ Employee + Family

DENTAL PLAN

☐ Elect Coverage
☐ Waive Coverage

Coverage Level:
☐ Employee Only
☐ Employee + Spouse/Partner
☐ Employee + Child(ren)
☐ Employee + Family

VISION PLAN

☐ Elect Coverage
☐ Waive Coverage

Coverage Level:
☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or More Dependents

Family Member Information: List only members to be covered.

NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	BIRTH DATE: MO./DATE/YEAR	RELATIONSHIP	*CHECK [✓] COVERAGES SELECTED:* MEDICAL	DENTAL	VISION	*CHANGES ONLY:* ADD	DELETE	SOCIAL SECURITY NUMBER
EMPLOYEE	☐ M ☐ F	/ /		☐	☐	☐			
SPOUSE/PARTNER	☐ M ☐ F	/ /		☐	☐	☐			
DEPENDENT CHILD	☐ M ☐ F	/ /		☐	☐	☐			
DEPENDENT CHILD	☐ M ☐ F	/ /		☐	☐	☐			
DEPENDENT CHILD	☐ M ☐ F	/ /		☐	☐	☐			

ACCEPTANCE AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I request the coverages for myself and any eligible dependents as listed on this form and authorize Colorado College to deduct from my pay my contributions (if any) for the cost of all the above enrolled benefits. I further understand that all applicable deductions will be on a pre-tax basis unless I request in writing to have deductions post-tax. I give you permission to give all carriers any information about me and the dependents listed necessary for determining eligibility for coverage, benefits, risk classification, detecting or preventing fraud or misrepresentation, audits, and for claims administrative purposes. The word "you" refers to any organization or person that has records or knowledge about my or my dependent's medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This includes my employer, any provider of health care, insurance companies from whom I have purchased insurance, and other insurance support agencies. The carriers may also give this information to their legal representatives and reinsurers. I give the carriers, their legal representatives, any person or organization administering claims on behalf of the carriers, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group plans or for the purpose of conducting an audit of the carriers' operations or services. The summary of claims may identify the person for whom services were provided, the nature of the condition, the date and nature of services rendered, the provider of the services, and the amount of the claim. This summary of claims will be provided in aggregate and disclosed in a format that will not identify the person by name with his/her condition. I agree to be bound by all terms of the plans under which I am applying for coverage. This authorization applies for as long as I have coverage under the plans. I agree that a copy of this authorization shall be as valid as the original. I certify that, to the best of my knowledge, the information shown on this enrollment form is correct. 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. By my signature below, I acknowledge that I have read and understand this disclosure.

Signature of Employee: _____ Date Signed: _____