Health, Dental, and Vision Enrollment/Change Form

Instructions: Form is only to be used for new employees or qualifying event changes during the plan year (outside of annual Open Enrollment). For new hire enrollment, **this completed form must be submitted to your employing organization's HR/Benefits Office within 30 days of the first of the month that benefits coverage becomes effective**. Visit the Statewide Benefits Office (SBO) qualifying events page to learn more about qualify event enrollment and timelines.

Before finalizing enrollment selections, visit the SBO website at de.gov/statewidebenefits, select your group, and choose "Enrollment" for helpful resources including plan rates and information, plan comparison charts, online benefit courses, new hire enrollment quick reference guide, myBenefitsMentor®, and more. The SBO website also contains important policies and procedures, including the Group Health Insurance Plan (GHIP) Eligibility & Enrollment Rules, Spousal Coordination of Benefits Policy, and Dependent Coordination of Benefits Policy, as well as GHIP Notices.

Important Notice for K12, DTCC, and DSU Employees: Your benefits may be different from what is presented on this form. Please refer to the Resource Document for Education Employees or contact your employing organization's HR/Benefits Office for information regarding your benefits and premiums (rates).

Have questions about your benefits or this form? Contact your employing organization's HR/Benefits Office. You can also contact the SBO Customer Service Team at 1-800-489-8933 or benefits@delaware.gov.

Employee Information

First Name: _____ **Last Name**: _____

DOB: _____ **Gender**: _____ **SSN**: _____ **Employee ID**: _____

Employing Organization: _____

Status & Enrollment/Change Action Requested

☐ **New Employee** **Date of Hire:** _____

☐ **Change in Family Status** (Review Qualifying Events for details.)

- ☐ **Add Employee/Dependent(s)** due to:
  - ☐ Marriage/Civil Union **Date of Event**: _____
  - ☐ Birth/Adoption **Date of Event**: _____
  - ☐ Loss of Coverage **Date of Event**: _____
    Reason: _____
  - ☐ Other (Please Explain) **Date of Event**: _____
    Reason: _____
- ☐ **Remove Employee/Dependent(s)** due to:
  - ☐ Divorce **Date of Event**: _____
  - ☐ Death **Date of Event**: _____
  - ☐ Loss of Eligibility **Date of Event**: _____
    Reason: _____
  - ☐ Other (Please Explain) **Date of Event**: _____
    Reason: _____

State Health Benefits

Newly hired employees who want to enroll in a health plan are eligible for coverage with State Share on the first of the month following date of hire. State Share refers to the portion of their health plan premiums paid by the State. See the Group Health Insurance Plan (GHIP) Eligibility & Enrollment Rules for details about State Share.

Use the online myBenefitsMentor® Consumer Decision Tool to help you estimate upcoming healthcare expenses and make the best enrollment selection from the four health plans offered by the State of Delaware.

Enrollment in a health plan automatically enrolls you and eligible covered dependents in prescription plan benefits, the Employee Assistance Program (EAP), and SurgeryPlus. In addition, enrollment in a health plan provides you with access to preventive care, wellness and condition care management programs, discounts on gym memberships, weight-loss programs, and more. Visit the SBO website for details.

Important: If you select either "Employee & Spouse" or "Family" level for your health plan coverage, you must complete the online Spousal Coordination of Benefits (SCOB) Form within 30 days of enrolling a spouse in a State of Delaware health plan, within 30 days of a spouse losing or gaining employee coverage, and every year during the annual benefits Open Enrollment. Complete the form on the SBO website, "Select your Group" and then choose the Spouse and Dependents icon. The *Electronic Form* and a *Self-Service Guide* are located under the FORMS section on the "Spouse" tab.

If enrolling a dependent child in your health plan and they have other health coverage, you must complete a Dependent Child Coordination of Benefits (DCOB) Form (Highmark Delaware or Aetna) and submit it to the appropriate health carrier.

New Hire Enrollment/Change Option(s) for State Health Plan:

☐ Enroll in Coverage **Effective Date**: _____

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Aetna CDH Gold Plan	○	○	○	○
Aetna HMO Plan	○	○	○	○
Highmark First State Basic Plan	○	○	○	○
Highmark Comprehensive PPO Plan	○	○	○	○

☐ Waive Coverage *(I do not want to enroll in the State health plan)*

Qualifying Event Enrollment/Change Option(s) for State Health Plan:

☐ Add Employee **Effective Date**: _____
☐ Add/Remove Dependent(s) **Effective Date**: _____
☐ Cancel Coverage **Effective Date**: _____

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Aetna CDH Gold Plan	○	○	○	○
Aetna HMO Plan	○	○	○	○
Highmark First State Basic Plan	○	○	○	○
Highmark Comprehensive PPO Plan	○	○	○	○

☐ **No change to current State Health Plan enrollment.**

State Dental Benefits

Newly hired benefit-eligible employees may participate in a State dental plan effective on the first of the month following date of hire. Otherwise, they will not be eligible to participate again until the next Open Enrollment (unless they experience a qualifying event during the plan year). For qualifying event enrollment, the State dental plan effective date is always the first of the month following the qualifying event, unless the date of the qualifying event is the first of the month. Employees are responsible for paying the entire amount of the State dental plan premiums.

New Hire Enrollment/Change Option(s) for State Dental Plan:

☐ The first of the month following date of hire **Effective Date**: _____

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Dominion National DHMO Plan	○	○	○	○
Delta Dental PPO Plan	○	○	○	○

☐ Waive Coverage *(I do not want to enroll in the State dental plan)*

Qualifying Event Enrollment/Change Option(s) for State Dental Plan:

☐ Add Employee **Effective Date**: _____
☐ Add/Remove Dependent(s) **Effective Date**: _____
☐ Cancel Coverage **Effective Date**: _____

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Dominion National DHMO Plan	○	○	○	○
Delta Dental PPO Plan	○	○	○	○

☐ **No change to current State Dental Plan enrollment.**

State Vision Benefits

Newly hired benefit-eligible employees may participate in a State vision plan effective on the first of the month following date of hire. Otherwise, they will not be eligible to participate again until the next Open Enrollment (unless they experience a qualifying event during the plan year). For qualifying event enrollment, the State vision plan effective date is always the first of the month following the qualifying event, unless the date of the qualifying event is the first of the month. Employees are responsible for paying the entire amount of the State vision plan premiums.

New Hire Enrollment/Change Option(s) for State Vision Plan:

☐ The first of the month following date of hire **Effective Date**: _____

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
EyeMed Low Vision Plan	○	○	○	○
EyeMed High Vision Plan	○	○	○	○

☐ Waive Coverage *(I do not want to enroll in the State vision plan)*

Qualifying Event Enrollment/Change Option(s) for State Vision Plan:

☐ Add Employee **Effective Date**: _______________________
☐ Add/Remove Dependent(s) **Effective Date**: _______________________
☐ Cancel Coverage **Effective Date**: _______________________

	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
EyeMed Low Vision Plan	◯	◯	◯	◯
EyeMed High Vision Plan	◯	◯	◯	◯

☐ **No change to current State Vision Plan enrollment.**

Dependent Information

Please provide your dependent information below only for your spouse and/or dependent child(ren) you are adding or removing. Including Social Security Number (SSN) and date of birth assures your dependents are enrolled in the plans you select.

If enrolling in an HMO (Aetna or Dominion National) plan, you are required to select a primary provider for you and your covered dependents and include their provider ID numbers in the chart below. To locate the provider ID numbers, follow the instructions on the *find a provider* links: Aetna and Dominion National. Be sure to confirm the provider participates in the plan's network and is accepting new patients prior to enrolling.

Action	State Benefits	Relationship	First Name	Last Name	Gender	Date of Birth	SSN	PCP ID *(Aetna HMO Plan)*	Dentist ID# *(Dominion National Plan)*
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								
◯ Add ◯ Remove	☐ Health ☐ Dental ☐ Vision								

Required Supporting Documentation

The following documentation must be provided along with this completed form to your employing organization's HR/Benefits Office, as your HR/Benefits Office will make copies and store the copies in your file:

Upon initial enrollment:

- **Employee**: Social Security card
- **If enrolling a spouse**: Spouse's Social Security card and marriage certificate
- **If enrolling a dependent child(ren):** Social Security card for each dependent child and their birth certificate/legal document

Other enrollment or removal of spouse and/or dependent child(ren) scenarios:

Supporting documentation must be provided with this completed form. Review the Required Documentation list on the SBO website.

Other Benefits Administered by the Statewide Benefits Office (SBO)

In addition to health, dental, and vision benefits, the State of Delaware provides other benefits which you may be interested in enrolling. These benefits include Life Insurance, Accident & Critical Illness Insurance, Flexible Spending Account (FSA), and Pre-Tax Commuter Benefit Program. View the "Enroll or Make Changes" section of each of plan's page to learn more about enrollment for new hires and qualifying event enrollment.

Newly hired or rehired employees in positions covered by the Delaware State Employees' Pension Plan are automatically enrolled in the Disability Insurance Program (DIP). Benefits under the DIP include Short Term Disability (STD), Long Term Disability (LTD), and Return To Work Assistance. Learn more.

Employee Acknowledgement and Signature

By my signature below, I hereby certify the benefit selections made on this form are true and my choice. I have completed the required forms and submitted the necessary documentation to enroll/disenroll in the benefit selections chosen. I understand that, by completing and signing the required forms, I am affirming that any dependents noted are eligible dependents based on the State's Group Health Insurance Plan (GHIP) Eligibility and Enrollment Rules, Spousal Coordination of Benefits Policy, and Dependent Coordination of Benefits Policy, and that I am making a binding election with regard to my benefits for the current plan year unless I have a permissible family status change as defined by the Internal Revenue Service, or I terminate employment with the State of Delaware. I acknowledge by submitting this signed form that I am responsible for required premiums. I authorize the State to collect the required premiums from my paycheck.

Employee Signature: _____ **Date**: _____

FOR HR/BENEFITS OFFICE USE ONLY

Data entry in PHRST must be completed as soon as possible, so the enrollment can be sent to the health, dental, and/or vision carriers in the weekly file, the enrollment loaded, and member ID cards sent.

As a reminder, full-time benefit eligible employees should be enrolled in Plan Type 10. Part-time benefit eligible employees should be enrolled in Plan Type 13 (as they are not eligible for State Share and are required to pay the entire monthly premium).

A copy of this completed form must be saved in the employee's medical file. Review the Required Documentation list on the SBO website for other enrollment or removal of spouse and/or dependent child(ren) scenarios, in order to assure employees submit the necessary documents to you along with this form.

Date Form and Supporting Documentation Received: _____

Date Information Entered in PHRST: _____

HR/Benefits Representative Name: _____

HR/Benefits Representative Signature: _____