Employee Benefit Plans Enrollment/Change Form
January 1, 2024 – December 31, 2024

PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED

Completed forms may be emailed to smartinez@cortez.k12.co.us

Employee Information

Employee Name (Last, First, MI):	Social Security Number: (Last 4) XXX-XX-	Date of Birth:
Street Address, City, State, Zip Code:	Phone Number:	Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married		

Type of Enrollment	Reason for Change
☐ Open Enrollment ☐ New Hire ☐ Add dependent(s) ☐ Cancel employee ☐ Cancel dependent(s)	☐ Marriage ☐ Divorce/Legal Separation ☐ Change in spouse employment status ☐ Birth, adoption, or placement for adoption ☐ Death of a dependent ☐ Other: ____

BENEFIT PLAN ELECTIONS

Medical Coverage

Anthem Plan A HSA ($4000 deductible)	Anthem Plan B ($2000 deductible)	Anthem Plan C ($1000 deductible)
☐ Employee Only ($0.00 per pay period)	☐ Employee Only ($44.00 per pay period)	☐ Employee Only ($131.00 per pay period)
☐ Employee + Spouse ($504.00 per pay period)	☐ Employee + Spouse ($577.00 per pay period)	☐ Employee + Spouse ($656.00 per pay period)
☐ Employee + Child(ren) ($419.00 per period)	☐ Employee + Child(ren) ($515.00 per period)	☐ Employee + Child(ren) ($585.00 per period)
☐ Employee + Family ($855.00 per pay period)	☐ Employee + Family ($1,003.00 per pay period)	☐ Employee + Family ($1,193.00 per pay period)
☐ Dual Employee + Spouse ($0.00 per period)	☐ Dual Employee + Spouse ($86.00 per period)	☐ Dual Employee + Spouse ($262.00 per period)
☐ Dual Employee + Family ($195.00 per period)	☐ Dual Employee + Family ($313.00 per period)	☐ Dual Employee + Family ($503.00 per period)

☐ **Waive Medical**

Health Savings Account (HSA) – If electing the Anthem HDHP Medical Plan

The **USA Patriot Act of 2001** requires financial institutions to obtain, verify, and record information to confirm the identity of everyone that opens an account. The bank you choose to open your HSA will reach out to you to complete this process. **You will need to submit a voided check with the account type, routing, and account number to Human Resources (can be a letter or document from your bank). The account needs to be a separate account that you can only use for HSA contributions.**

☐ **I certify that I am eligible to contribute to an HSA and my annual contribution will not exceed the amount permitted. I also certify the purpose and funds for this account are for a Health Savings Account (HSA).**

☐ Single Coverage ($4,150 Max): $________________________
☐ Family Coverage ($8,300 Max): $________________________
☐ Over age 55 Catch Up Contribution ($1,000 Max): $_________________________

☐ **Waive HSA/Not Eligible**

FSA (Flexible Spending Account)

Montezuma-Cortez School District has partnered with Rocky Mountain Reserve to administer FSA services beginning January 1, 2023. An FSA consists of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

☐ I certify that I am eligible to contribute to an FSA and my annual contribution will not exceed the amount permitted. I also certify the purpose and funds for this account are for a Flexible Spending Account.

☐ FSA Election ($3,200 Max): $________________________
☐ Dependent Care ($2,500 Single/$5,000 Family Max): $_________________________
☐ Limited Health FSA ($3,050 Max, Dental and Vision, only applicable if you have HDHP): $__________________________
Remember the "use it or lose it rule."

☐ **Waive FSA/Not Eligible**

Dental Coverage

Anthem Dental

☐ Employee Only ($34.80 per pay period)
☐ Employee + Spouse ($75.21 per pay period)
☐ Employee + Child(ren) ($66.41 per pay period)
☐ Employee+ Family ($106.97 per pay period)

☐ **Waive Dental**

Vision Coverage

SunLife – VSP Network Coverage

☐ Employee Only ($8.19 per pay period)
☐ Employee + Spouse ($16.26 per pay period)
☐ Employee + Child(ren) ($17.84 per pay period)
☐ Employee + Family ($25.67 per pay period)

☐ **Waive Vision**

Basic Life and AD&D

Employer paid

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes

Voluntary Life and AD&D

Disability STD and LTD (60% of weekly income for STD max $1,000, 60% of monthly income for LTD, max at $6,000)

Voluntary Life Rates per $1,000

Age	Rate
Under age 25	$0.065
25-29	$0.060
30-34	$0.080
35-39	$0.107
40-44	$0.164
45-49	$0.252
50-54	$0.397
55-59	$0.618
60-64	$0.902
65-69	$1.490
70-74	$3.429
75-99	$8.317
Child Life	$0.207

AD&D Per $1,000

EE /SP AD&D	$0.041
Child AD&D	$0.041

Short Term Disability Rates per $10

Age	Rate
Under age 20	$0.462
20-24	$0.462
25-29	$0.488
30-34	$0.490
35-39	$0.460
44-44	$0.478
45-49	$0.519
50-54	$0.598
55-59	$0.714
60-64	$0.837
65-69	$0.938
70-74	$1.220
75+	$1.586

☐ Waive Short Term Disability

☐ Elect Short Term Disability

Long Term Disability Rates per $100 Covered Payroll

Age	Rate
Under age 25	$0.065
25-29	$0.060
30-34	$0.080
35-39	$0.107
40-44	$0.164
45-49	$0.252
50-54	$0.397
55-59	$0.618
60-64	$0.902
65-69	$1.490
70-74	$3.429
74+	$8.317

☐ Waive Long Term Disability

☐ Elect Long Term Disability

Employee Life (Max of 5x salary or $500,000 with a guaranteed issue of $100,000)	Spousal Life insurance (Max of 50% employee life or $250,000)	Child Life Insurance (increments of $5,000 with a $10,000 benefit) children up to age 26
☐ Enroll in Spousal Life ($5,000 increments, guaranteed issue $30,000)	☐ Enroll in Employee Life ($10,000 increments).	☐ Enroll in Child Life
$______________________ coverage elected	$______________________ coverage elected	$______________________ coverage elected
☐ **Waive Employeel Life Insurance**	☐ **Waive Spouse Life Insurance**	☐ **Waive Child Life Insurance**

Critical Illness

Employee Critical Illness

☐ $10,000 coverage
☐ $20,000 coverage
☐ $30,000 coverage

*See Anthem Rate grid or contact HR for assistance calculating rates based on coverage, age, and/or tobacco/non tobacco use

☐ Employee & Spouse/Family Critical Illness

☐ Waive Employee & Spouse/Family Critical Illness

Hospital Indemnity

☐ Employee Hospital Indemnity Low Plan
☐ Employee Hospital Indemnity High Plan
☐ Waive Employee Hospital Indemnity

*See Benefit Enrollment Guide 2024 for payout

Rates	Low	High
Employee	$8.61	$15.25
Employee + Spouse	$17.87	$31.69
Employee + Child(ren)	$13.33	$23.55
Employee + Family	$23.26	$41.15

Accident

☐ Employee Accident Low Plan
☐ Employee Accident High Plan
☐ Waive Employee Accident

*See Benefit Enrollment Guide 2024 for payout

Rates	Low	High
Employee	$5.75	$7.27
Employee + SP	$9.02	$11.27
Employee + Child(ren)	$9.80	$11.80
Employee Family	$15.32	$18.62

Voluntary Life Example

If a 37- year-old employee elects $100,000 in Life/AD&D for them and $30,000 for their spouse. They would use the $.080 rate to calculate the life premium and the $0.041 to calculate the AD&D premium. The calculation is shown below.

Employee Premium
$\$0.080\ x\ 100 = \$8.00$
$\$0.041\ x\ 100 = \$4.10$
$\$12.10/Month$

+

Employee Premium
$\$0.080\ x\ 30 = \$3.00$
$\$0.041\ x\ 30 = \$1.23$
$\$4.23/Month$

=

Total Monthly Cost
$\$16.33$

Short Term Disability Example (per $10)

Employee Benefit: $Annual\ Salary/52\ x\ .60$

Example using $40,000 annual salary for age 37

1. $40,000/52 = \$769.23$
2. $\$769.23\ x\ 0.60 = \$461.54$ **(round up to next $10 = $470)**

Total Monthly Cost: $21.62
Total Weekly Benefit: $470

Long Term Disability Example (per $100)

Employee Benefit: $Annual\ Salary/12\ x\ .60$

Example using $40,000 annual salary for age 37

1. $40,000/12 = \$3,333.33\ x\ 0.60 = \$2,000$

Premium is calculated by total salary and not benefit below is how you would calculate your premium

2. $40,000/12\ x\ 0.711/100 = \$21.62\ Monthly\ Cost$

Total Monthly Cost: $23.70
Total Monthly Benefit: $2,000

Dependent Information

Action	Name (First, Last, MI)	Relationship	Birth Date (mm/dd/yyyy)	Sex	Social Security Number (full)	Coverage
☐ Add ☐ Drop		☐ Spouse ☐ Child ☐ Stepchild ☐ Other:		☐ Male ☐ Female		☐ Medical ☐ Dental ☐ Vision ☐ Beneficiary
☐ Add ☐ Drop		☐ Spouse ☐ Child ☐ Stepchild ☐ Other		☐ Male ☐ Female		☐ Medical ☐ Dental ☐ Vision ☐ Beneficiary
☐ Add ☐ Drop		☐ Spouse ☐ Child ☐ Stepchild ☐ Other		☐ Male ☐ Female		☐ Medical ☐ Dental ☐ Vision ☐ Beneficiary
☐ Add ☐ Drop		☐ Spouse ☐ Child ☐ Stepchild ☐ Other		☐ Male ☐ Female		☐ Medical ☐ Dental ☐ Vision ☐ Beneficiary
☐ Add ☐ Drop		☐ Spouse ☐ Child ☐ Stepchild ☐ Other		☐ Male ☐ Female		☐ Medical ☐ Dental ☐ Vision ☐ Beneficiary

Authorization

Employee Statement and Signature

Dependents: I verify and attest that my dependents are eligible for the coverage for which I am applying. I understand that I am responsible for notifying within 30 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable and may become my sole responsibility.

Authorization

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back page, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem and me.
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.

Description of Special Enrollments

If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of other health insurance or group health
plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of coverage under a state child health insurance program, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program. However, you must request enrollment within 60 days after the date the coverage under a state child health insurance program ends.

If you decline health coverage for yourself or your dependent(s) (including your spouse/designated beneficiary/domestic partner) because of coverage under a state Medicaid plan, you may be able to enroll yourself and your dependents in this plan if you or your dependent(s) lose eligibility under a state Medicaid plan. However, you must request
enrollment within 60 days after the date the coverage under a state Medicaid plan ends. If you become eligible for state premium assistance for group coverage, you may be able to enroll yourself and your dependent(s) (including your spouse/designated beneficiary/ domestic partner) in this plan. However, you must request enrollment within 60 days after the date you become eligible for state premium assistance for group coverage.
In addition, if you have a new dependent as a result of marriage/Signed Common-Law Certificate/Civil Union Registration/Recorded Designated Beneficiary Agreement/ Certificate of Domestic Partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption.

In addition, a person may be entitled to a special enrollment pursuant to a qualified medical child support order or other court or administrative order mandating that the individual be covered. If enrolling due to special enrollment, Anthem will request legal proof of the actual qualifying event. Such documents may include, but are not limited to, court orders, marriage certificates, civil union registrations, and designated beneficiary agreements. For common law and domestic partner coverage, please fill out sections 8 or 9 on the Anthem application. To request special enrollment, submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-877-811-3106 or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

I understand that Montezuma Cortez School District (MCSD) RE-1 offers me medical benefits that meet Minimum Essential Coverage (MEC), Minimum Value Coverage (MVC), and Affordability requirements under the Affordable Care Act. If I decline coverage through MCSD RE-1, I understand that I am not eligible to receive premium subsidies from a state or federal insurance exchange/marketplace.

By providing my signature below, I am verifying that the information provided above is true and correct to the best of my knowledge.

Employee Signature	Date