CHRISTINA SCHOOL DISTRICT

Together, Educating Every Student for Excellence

Effective Date: (For office use Only)

Benefit Enrollment and Change Form

This form MUST be completed, signed, dated, and returned within 30 days. If no election is made, benefits will be WAIVED.

Employee Name	Employee ID#	Social Security #	Date of Birth

Phone #	Street Address	City, State Zip
Email Address (Print Clearly)		

SPOUSAL COORDINATION OF BENEFITS FOR HEALTH COVERAGE

Is your spouse a **STATE OF DELAWARE** Employee or Pensioner? (If **yes**, complete)

Spouse's Name: _____ Spouse's SSN: _____

Agency Name: _____ Spouse's Birth Date: _____

COVERAGE ELECTION EVENT (Circle One)

ADD COVERAGE	☐ New Hire	☐ Marriage	☐ Birth/Adoption/ Guardian	☐ Change in Employment
DROP COVERAGE	☐ Divorce	☐ Change in Employment	☐ Death	☐ *Other (Explain Below)

*

HEALTH INSURANCE				
Check One Plan Type	☐ Highmark DE **Comprehensive** PPO	☐ Aetna **HMO**	☐ Aetna **CDH Gold**	☐ Highmark DE **First State Basic**
Check One Coverage Type	☐ Employee	☐ Employee & Spouse	☐ Employee & Child(ren)	☐ Family
☐ **DECLINE MEDICAL COVERAGE**				

DENTAL INSURANCE				
Check One Plan Type	☐ Plan A	☐ Plan B		
Check One Coverage Type	☐ Employee	☐ Employee & Spouse	☐ Employee & Child(ren)	☐ Family
☐ **DECLINE DENTAL COVERAGE**				

VISION INSURANCE				
Check One Coverage Type	☐ Employee	☐ Employee & Spouse	☐ Employee & Child(ren)	☐ Family
☐ **DECLINE VISION COVERAGE**				

District Life/AD&D Insurance (Check One)	
☐ Enroll	☐ Decline Coverage

LTD Supplemental Disability (Check One)	
☐ Enroll	☐ Decline Coverage

Additional Information: https://www.christinak12.org/benefits

Questions: CSDPayrollBenefits@christina.k12.de.us

Over--->

If enrolling in the **Aetna HMO Medical Plan**, include the Primary Care Physician's ID number for yourself and each covered family member.

Search for the PCP ID# at this website: https://dhr.delaware.gov/benefits/medical/aetna/doc-find.shtml

Dependent Information

Dependent Name(s)	A-Add, D-Drop	Social Security #	Birth Date	M-Medical, D-Dental, V-Vision (Select Coverage)			Relationship EE-Employee Sp-Spouse D-Daughter S-Son	PCP ID# (Aetna HMO Only)
				M	D	V		

Dependents Age Out - End of the month that age 26 is reached

IF ADDING A SPOUSE, PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE/CIVIL UNION CERTIFICATE AND A LEGIBLE COPY OF THE SPOUSE'S SOCIAL SECURITY CARD.

If adding a spouse to Medical, employee must read the Spousal Coordination of Benefits policy and submit an online Spousal Coordination of Benefits form as outlined in your packet on the Coordination of Benefits Information Sheet.

IF ADDING A DEPENDENT CHILD(REN), PROVIDE A COPY OF THE BIRTH CERTIFICATE AND A LEGIBLE COPY OF THE SOCIAL SECURITY CARD FOR EACH DEPENDENT.

If covering a Dependent Child (to age 26), employee must read the Dependent Coordination of Benefits Policy and submit a Dependent Coordination of Benefits form (if applicable) as outlined in your packet on the Coordination of Benefits Information Sheet.

CERTIFICATION (must sign and date)

By my signature below, I hereby certify that the benefit elections I have made on this form are the benefit elections I have chosen, and that I have completed the required forms necessary to enroll. I understand that by completing and signing the required forms, I am making a binding election regarding my benefits for the current plan year unless I have a permissible status change as defined by the Internal Revenue Service or I terminate my employment with the State of Delaware. I understand and agree my regular pay will be reduced by the required contribution amount for the benefit options I have elected. I understand if employment ends I am eligible to continue District Life Insurance by contacting the insurance carrier within 30 days of termination date for conversion to an individual coverage.

Employee Signature: _____ Date _____

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Questions: CSDPayrollBenefits@christina.k12.de.us