Colonial School District Enrollment Form (Full-Time Only)

ENROLLMENT FORM MUST BE RETURNED TO BENEFITS OFFICE WITHIN 30 CALENDAR DAYS OF START DATE. Email scanned forms to Deldra.Gregory-Colvin@colonial.k12.kde.us or Fax to (302) 323 2748.

Employee Last	Employee First	M.I	Birth Date	EMPLID	SSN

Address:

Double State Share & Spousal Coordination – Does your spouse work for the State of DE? Y or N

If Yes	Agency Name:	Hire Date:
If Yes	Spouse Full Name:	
	Spouse's Birth Date	Date of Marriage:

Group Health Rates Effective 7/1/2021

State of Group Health Plans – During 3-month waiting period.

Coverage Effective Date:	Circle Plan and Coverage Level or Waive			
Monthly Deduction w/stipend	**Employee**	**Emp/Spouse**	**Emp/Children**	**Family**
Highmark First Basic PPO	535.36	1278.68	897.02	1638.42
Aetna CDH Gold Plan	559.68	1332.22	939.56	1735.74
Aetna HMO	565.94	1370.58	950.52	1749.82
Highmark Comprehensive PPO	633.86	1487.34	1063.46	1899.40
Waive all plans during waiting	Yes			

State of Group Health Plans – After waiting 3-month ends.

Coverage Effective Date:	Circle Plan and Coverage Level or Waive			
Monthly Deduction w/stipend	**Employee**	**Emp/Spouse**	**Emp/Children**	**Family**
Highmark First Basic PPO	0.00	0.00	0.00	0.00
Aetna CDH Gold Plan	0.00	0.00	0.00	0.00
Aetna HMO	0.00	0.00	0.00	0.00
Highmark Comprehensive PPO	0.00	58.26	2.08	112.86
Waive all plans during waiting	Yes			

Local Benefits (Dental, Vision & Life) Rates Effective 7/1/2021

Employee are allotted $142.50 for the following benefits

Dental Coverage Effective Date:	Circle Plan and Coverage Level or Waive			
Monthly Deduction	**Employee**	**Emp/Spouse**	**Emp/Children**	**Family**
Cigna Plan A	61.90	97.46	121.06	165.84
Cigna Plan B	48.38	75.44	93.60	128.26
Waive all Dental Plan	Yes			
Vision Coverage Effective Date:	Circle Plan and Coverage Level or Waive			
Monthly Deduction	**Employee**	**Emp/Spouse**	**Emp/Children**	**Family**
VBA	15.04	28.20	25.80	39.14
Waive all Vision Plan	Yes			

District TERM Life/AD&D Insurance –up to 2x annual base salary rounded up to next 500

I am enrolling in the District's Term Life Insurance	YES	NO

To determine cost of life insurance: Step 1 – Multiple Annual Salary by 2. Step 2 – Round up to the nearest 500. Step 3 – Multiple by insurance factor 1.444 to determine yearly amount. Step 4 – divide by 24 to obtain per pay deduction. Example with Annual Salary of $16,432. Step 1 – 16.342*2 =$32,864 Step 2 -33,000 Step 4 33000*1.444= 47.52 Step 5 47.52/24 = 1.98 per pay

PERSONAL INFORMATION

Children, step-children, adopted children are covered under all plans to the end of the month in which they reach age 26. Coverage for grandchildren (for whom you have legal custody or guardianship) are covered until the end of the month in which they reach age 19, or, if a Full Time Student, then end of the month in which they reach age 24.

List self and dependents, "√" plan codes for each dependent

Last Name, First/Middle	**Social Security #**	**Date Of Birth**	**"√" Plan Codes** **H**=Health/ExpressRX **D**=Dental, **V**=Vision **H**	**D**	**V**		**Physician ID# HMO Plans**	**Relation** **SP=**Spouse **S=**Son **D=**Daughter **O=Other**
Self								
Spouse								
Child								
Child								

Benefits Information and video are available online at www.schooldistrictbenefits.com/colonial and State benefits information including HIPAA Privacy Notice is available online at http://ben.omb.delaware.gov/hipaa/index.shtml.

CHECKLIST:

View Benefits Information and Video at www.schooldistrictbenefits.com/colonial

Enrollment Elections - "√" to indicate election for each section

If Enrolling Spouse:

Complete Online Spousal Form www.ben.omb.delaware.gov/documents/cob,

Attach a copy of the Marriage/Civil Union Certificate

If Enrolling Children:

Complete Coordination of Benefits Form https://ben.omb.delaware.gov/documents/cob/dep-child.shtml

Attach a copy of the Birth or Legal Documents for each dependent also included snn cards

List a Physician I D # if selecting Aetna HMO Plan

District Dental Insurance - See dependent age limits above

District Vision Insurance - See dependent age limits above

District Life Insurance – Complete Beneficiary Form

Flexible Spending Account –*Enrollment form*

http://ben.omb.delaware.gov/fsa/documents/enrollment-agreement.pdf

CERTIFICATION: By my signature below, I certify the benefit elections on this form and understand these are binding elections that cannot be changed unless I have a permissible status change as defined by the Internal Revenue Service or terminate employment with the State/District. I understand my pay will be reduced by the required amount, if the benefits I select are over the provided stipend amounts. I understand if employment ends, I am eligible for Life Insurance continuance, provided I contact the Benefits Office and request a Conversion Form no later than 30 days from my termination date.

SPECIAL ENROLLMENT RIGHTS: If I decline enrollment for myself, spouse and dependents because of other insurance coverage and later loose eligibility for that other insurance, I may be able to enroll in this plan, provided I request enrollment within 30 days of the other coverage end date. In addition, if I have a marital status change, my spouse has an employment status change or I have a new dependent as a result of marriage, birth, or adoption, I may be able to enroll myself, and my dependents provided I request enrollment within 30 days of the event date**.** Failure to notify the Benefits Office within 30 days will result in waiting until the next Enrollment Period (State Eligibility Rules 3.05).

Additional benefits information, HIPAA Privacy Notice and Special Enrollment Rights for Individuals Eligible for the Delaware Health Children Program (CHIP), is available online at www.ben.omb.delaware.gov

Employee Signature: _____ Date: _____