Group #H880141

Division Code:

MID-YEAR CHANGE
ENROLLMENT FORM: PLAN YEAR 2021

Please Print. Add additional pages if needed ***Complete All Areas***

This form must be completed and returned to Gunnison County Human Resources within 30 days of your QUALIFYING LIFE EVENT.

Date of Qualifying Life Event:		**Benefits Effective Date:**	
Social Security #:	**Last Name:**	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State:**	**Zip Code:**
Email Address (required):			
Gender:	**Date of Birth:**	**Marital Status:**	**Employee Phone Numbers: Home:**
			Cell: **Work:**

Circle (A) Add, (T) Term or (W) Waive	**Self, Spouse & Dependent children (eligible to age 26) Last Name, First Name**	**Relationship** (i.e., self, spouse, natural child, stepchild, legal guardianship, etc.)	**Date of Birth**	**Gender M/F**	**Dependent Social Security Number**
A / T / W					
A / T / W					
A / T / W					
A / T / W					
A / T / W					
A / T / W					

Reason for Change (Qualifying Life Event):

□ Change in Marital Status (marriage, death of spouse, divorce or legal separation)

□ Birth, adoption, placement for adoption or death of a dependent

□ Termination or commencement of employment for your, spouse, or dependent

□ Relocation or increase in hours of employment by you or your spouse

□ Your dependent child satisfies or ceases to satisfy the requirements for coverage because of age 26

□ Mid-year eligibility for gain or loss of Medicare or Medicaid

□ A change in place of residence or work for you, your spouse or dependent

□ A judgement, decree or order requiring dependent coverage (e.g. QMCSO)

□ You or your spouse experiences an open enrollment event

Notes (optional):

FIRST NAME:	LAST NAME:

SELECT YOUR PLAN(S) TO CHANGE: select only one plan for you and your eligible dependent(s).
Employee Premium rates listed are per payroll period and are deducted on a pre-tax basis for the following coverage period. Rates are the employees' responsibility.

TIERS	TRADITIONAL	
SINGLE	☐	$185.22
EE+SPOUSE	☐	$555.67
EE+CHILDREN	☐	$518.63
FAMILY	☐	$889.08

TIERS	HDHP	
SINGLE	☐	$149.56
EE+SPOUSE	☐	$448.67
EE+CHILDREN	☐	$418.76
FAMILY	☐	$717.88

TIERS	DENTAL	
SINGLE	☐	$26.12
*EE+1	☐	$52.23
FAMILY	☐	$78.34

TIERS	VISION	
SINGLE	☐	$4.56
*EE+1	☐	$9.32
FAMILY	☐	$13.54

***If adding, which dependent (spouse, child, etc.) are you designating as your + 1?** _____

AUTHORIZATION
/ASSIGNMENT

I hereby apply for benefits under the group benefit plan(s) provided by my employer subject to all of its terms, conditions and provisions. I represent that all information provided above is true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements about myself or my named dependents may result in claim denial or termination of coverage if such information materially affects eligibility for coverage. If a contribution towards the cost is required, I authorize the necessary deductions from my earnings. I further authorize and direct that all benefit payments be made directly to the health care provider rendering a health care service payable under the plan(s).

Signature: _____ Date: _____