Christina School District

ADD/DROP DEPENDENT(S) FORM

NOTE: **BENEFIT CHANGES WILL NOT BE PROCESSED IF FORM IS INCOMPLETE OR REQUIRED PAPERWORK IS NOT INCLUDED.**

CANCEL COVERAGE DUE TO: □ DIVORCE □ INELIGIBLE (OVER AGE) DEPENDENT □ DEATH □ EMPLOYMENT CHANGE

ADD COVERAGE DUE TO: □ MARRIAGE /CIVIL UNION □ BIRTH/ADOPTION/GUARDIANSHIP □ EMPLOYMENT CHANGE

□ OTHER_____ **EFFECTIVE DATE:** _____

EMPLOYEE NAME	ADDRESS	HOME #	CELL #
SOCIAL SECURITY #		WORK LOCATION	Work #

HEALTH COVERAGE PLANS (select plan choice and coverage type below) □ **REFUSING HEALTH COVERAGE**

BLUE CROSS BLUE SHIELD □ **Comprehensive PPO** □ **Blue Care** □**BCBS Gold** □ **First State Basic** □ **Aetna HMO** □ **Aetna GDH Gold**

COVERAGE TYPE: □ **Employee** □ **Employee & Spouse** □ **Employee & Child (ren)** □ **Family**

DENTAL ENROLLMENT (Select Plan Choice) □**PLAN A** □ **PLAN B** □ **REFUSING DENTAL COVERAGE**

Coverage Type: □ **Employee** □**Employee & Spouse** □ **Employee & Child(ren)** □ **Family**

ENROLLMENT INFORMATION **List dependent(s) and benefit plan code selections below**

ADD √	**DROP √**	**Dependent's/ Name**	**Dependent's Social Security #**	**Birth Date**	**Plan Codes** M = State Medical & Prescription D=Dental V=Vision P= District Prescription M	D	V	P	**Primary Physician's Name for AETNA**	**Primary Physician's ID# for Blue Care**	**Relation** Sp=Spouse D =Daughter S= Son	**Full Time Student**	**Disabled**
												□	□
												□	□
												□	□
												□	□
												□	□

State Medical & State Medco Prescription Dependent Coverage ends: End of month 26 is reached

District Dental , District Vision & District Aetna Supplemental Prescription Dependent Coverage ends: End of month age 26 is reached

_____ _____ _____

Employee Signature Date Employee ID#

Christina School District

ADD/DROP DEPENDENT(S) FORM

√ CHECKLIST

- ❑ **IF ADDING A SPOUSE FOR THE FIRST TIME, COMPLETE A SPOUSAL COORDINATON OF BENEFITS FORM ON LINE AT https://secomb.delaware.gov/cob/ AND ATTACH A COPY OF THE MARRIAGE/CIVIL UNION CERTIFICATE.**

- ❑ **IF SPOUSE IS BEING ADDED DUE TO AN EMPLOYMENT STATUS CHANGE, PROVIDE PROOF WITH DATE OF BENEFIT CHANGE OR LOSS OF COVERAGE, COMPLETE A SPOUSAL COORDINATION OF BENEFITS FORM AT https://secomb.delaware.gov/cob/ AND ATTACH A COPY OF THE MARRIAGE /CIVIL UNION CERTIFICATE.**

- ❑ **IF ENROLLING A DEPENDENT CHILD FOR THE FIRST TIME, ATTACH A COPY OF THE BIRTH CERTIFICATE OR LEGAL DOCUMENT, PRINT,COMPLETE AND ATTACH AN ADULT DEPENDENT COORDINATION OF BENEFITS FORM FOUND AT http://ben.omb.delaware.gov/documents/cob/2011_Adult_Dependent_Form.pdf**

- ❑ **IF MAKING A NAME OR ADDRESS CHANGE, PLEASE COMPLETE NOTIFICATION OF CHANGE FORM. FOR NAME ATTACH A COPY OF SOCIAL SECURITY CARD SHOWING NEW NAME (REQUIRED BY STATE)**

- ❑ **IF DROPPING A SPOUSE DUE TO DIVORCE OR LEGAL SEPARATION ATTACH LEGAL DOCUMENTATION.**

- ❑ **IF APPLICABLE, UPDATE PENSION BEN-1 CHANGE OF BENEFICIARY FORM http://www.delawarepensions.com/forms/Documents/changeofbeneficiary_ben1.pdf**

  AND IF ENROLLED IN DISTRICT LIFE INSURANCE COMPLETE BENEFICIARY FORM

  http://www.schooldistrictbenefits.com/forms/BeneficiaryDesignation.pdf

NOTE: All forms must be returned to the Benefits Office within 30 days of the qualifying event to complete the enrollment process. Failure to submit the required paperwork within the 30-day period will result in waiting until the next Annual Open Enrollment Period. A dependent that is removed by request will not be reinstated until the next Annual Open Enrollment Period.