



CITY OF STAMFORD BENEFIT ENROLLMENT/CHANGE FORM

Benefits Department (203) 977-4523 or 977-4038. Fax: 203-977-4075

PERSONAL INFORMATION							
LAST NAME	FIRST NAME	M.I.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single			
			EMPLOYMENT STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA				
STREET ADDRESS		CITY		STATE	ZIP	TELEPHONE (H) _____ (C) _____	ENROLLMENT TYPE: <input type="checkbox"/> New Hire <input type="checkbox"/> Add Dependents <input type="checkbox"/> Other Changes
Social Security Number ____ - ____ - _____		CHANGE TYPE: <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Add Dependents <input type="checkbox"/> Drop coverage			QUALIFYING EVENT _____		UNION AFFILIATION
EFFECTIVE DATE / /				QUALIFYING EVENT DATE: / /			

EMPLOYEE AND FAMILY INFORMATION - Please list yourself and all eligible dependents to be enrolled. Eligible dependents include your spouse and/or children. Children can be covered until the end of the month in which they turn 26.

	LAST NAME, FIRST NAME, M.I.	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DEPENDENT STATUS	PRIMARY CARE PHYSICIAN #	PHYSICIAN'S FULL NAME
<input type="checkbox"/> SELF							
<input type="checkbox"/> SPOUSE							
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER							

I elect to enroll/dis-enroll in the coverage listed above and have chosen to enroll/dis-enroll the aforementioned dependents. I understand that this election is binding and cannot be changed until the next Annual Enrollment Period unless I experience a change in Family Status as outlined under Section 125 of the Internal Revenue Code. I hereby authorize my employer, The City of Stamford, to deduct the negotiated cost of this coverage from my paycheck. I agree and understand that my eligible dependents include my spouse and my biological, adopted and/or step children until their 26th.

Employee Signature: _____ Date: _____

Office Use Only	Employee ID# _____
<input type="checkbox"/> Ceridian <input type="checkbox"/> Cigna <input type="checkbox"/> Davis <input type="checkbox"/> Delta <input type="checkbox"/> Excel <input type="checkbox"/> Medco	

Following documents were reviewed for dependent eligibility: _____ Marriage Certificate, _____ Birth Certificate _____ Social Security Card REVIEWED/APPROVED BY: _____ DATE: _____
