



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
Street Address		City:		State:	Zip:	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA
Phone Number:		Social Security Number: ____-____-____		Qualifying Event:		Union Affiliation:
Effective Date: / /		Change Type: <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Add Dependents Drop Coverage		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"/> Single					N/A		
<input type="checkbox"/> Spouse					N/A		
<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# _____
 ___Ceridian ___Cigna ___Davis ___Delta ___Excel ___Maxor

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