STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM
EMPLOYEE ENROLLMENT/CHANGE FORM
For more information, visit the SBO website at de.gov/statewidebenefits

Form is only to be used for qualifying event changes during the plan year or for enrollment of new employees not employed by an Executive Branch Agency (and therefore not required to complete New Employee Orientation (NEO)).

Employee Name: ____ Hire Date: ____________________

Employee ID: _________________________ Organization: ____

Submission of this form will supersede any previous elections. Changes in coverage can only be made at the annual Open Enrollment period except for those instances outlined in the Group Health Eligibility & Enrollment Rules. Generally, if you are completing this form due to a qualifying event (marriage, civil union, divorce, birth, adoption, death or loss of coverage), you must make your request for the change to your HR/Benefits Office within 30 days of the qualifying event. The completed enrollment form and the required supporting documentation must be returned within 30 days of the request to your Human Resources/Benefits Office. If the completed enrollment form and required documents are not provided within the required timeframe, you must wait until the next Open Enrollment to change your benefit coverage.

Under the Joint Final Rule issued on April 28, 2020 by the U.S. Department of Labor, the Department of Treasury and the Internal Revenue Service, the state group health plan **must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the federal COVID-19 National Emergency** for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located **in determining the 30-day period to request special enrollment.** At this time, we do not know the date of the end of the federal COVID-19 National Emergency.

Supporting documentation of the qualifying event must be submitted with this form.

Employees are strongly encouraged to review the Group Health Eligibility & Enrollment Rules and the corresponding Benefit Program information, located on the SBO's website, before finalizing enrollment selections.

Reason for Application - Select the desired option by entering an "X".

New Coverage	Change Coverage	Terminate Coverage	Waive Coverage

Reason for Adding/Dropping Enrolled Member (including Spouse) - Select the desired option by entering an "X".
If adding a spouse or dependent because of the loss of coverage and/or employment as a result of the COVID-19 pandemic, please enter "COVID-19" in the Other/Explain in comments box below.

Marriage	Birth	Adoption	Divorce	Other/Explain in comments

Note: If employee is in a Civil Union and adding a Civil Union Spouse and/or Dependents, please refer to the Civil Union information on the SBO's website.

YOUR OPTIONS
Please refer to the Group Health Insurance Program Rate Sheet on the SBO website for prices for the options below.

Enrollment/Change is for – Enter the desired effective date (MM/DD/YY) of your requested action:

MEDICAL *(includes Prescription, DelaWELL Health Management Program and Employee Assistance Program)* - Coverage for the ex-spouse must be terminated on the day following the divorce

Insert eff. date (MM/DD/YY) applicable box below ↘	Employee Only	Employee & Spouse	Employee & Children	Family (Includes Employee)

Employee/Subscriber's Initial ______ Date _______

Aetna HMO				
Aetna CDH Gold				
Highmark Delaware Comprehensive PPO				
Highmark Delaware First State Basic				
Waive (I do not desire medical coverage)				

Additional Requirements:

For enrolled spouses: Benefits for a spouse may be reduced if coverage is available from the spouse's employer and your spouse does not enroll in his/her employer benefits. Please make sure to view the Spousal Coordination of Benefits information on the SBO website.

A Spousal Coordination of Benefits form must be completed if you have selected Employee & Spouse or Family Coverage. You MUST complete the Spousal Coordination of Benefits Form upon initial enrollment, anytime your spouse's employment or insurance status changes and each year during Open Enrollment. The Spousal Coordination of Benefits Policy information and electronic form can be found on the SBO website.

For enrolled children: A Dependent Coordination of Benefits form must be completed for each enrolled dependent regardless of age upon enrollment in other health coverage, any time other health coverage changes, or upon request by the Statewide Benefits Office or the State Plan administrator. The Dependent Coordination of Benefits Policy and carrier forms can be found on the SBO website.

See page 3 & 4 for more information about required documents for enrolling a spouse or dependent.

DENTAL - Coverage for the ex-spouse must be terminated on the day following the divorce

Insert eff. date (MM/DD/YY) applicable box below ↘	Employee Only	Employee & Spouse	Employee & Children	Family (Includes Employee)
Dominion National HMO Select Dental Plan				
Delta Dental PPO Plus Premier Plan				
Waive (I do not desire dental coverage)				

VISION – Coverage for the ex-spouse must be terminated on the day following the divorce

Insert eff. date (MM/DD/YY) applicable box below ↘	Employee Only	Employee & Spouse	Employee & Children	Family (Includes Employee)
EyeMed Vision Care Plan				
Waive (I do not desire vision coverage)				

To add a dependent to benefit coverage, please list the dependent's name and information, indicate the desired coverage plans for your dependents and indicate the Aetna HMO physician and/or Dominion National dentist number, if applicable. Aetna HMO and Dominion National provider information can be found using the "Find a Provider" link on the SBO website.

(If new coverage, employee information should be included on first row).

Name	SSN	Date of Birth	Relationship	Gender	Medical /Dental/Vision*	Physician ID#/Name (if Aetna HMO)	Dentist ID# (if Dominion)

Indicate **M for Medical, **D** for Dental and **V** for Vision.*

Employee/Subscriber's Initial ______ Date _______

Terminate Dependents (including Spouse):

Name of dependents to be terminated	Dep's SSN	Dep's date of birth	Reason for termination	Effective date for reason for termination	Termination Effective Date (to be complete by ben rep)

Comments: ____

Please ask your Human Resources/Benefits Office about the following benefit programs offered by the State of Delaware, which are not included on this enrollment form:

Life Insurance Program - *Flexible Spending Account Program (Health Care and Dependent Care) - Pre-Tax Commuter Benefit Program
****Accident & Critical Illness Insurance - COBRA***

Your qualifying event may also be a qualifying event for change or enrollment in these plans. **This is a time-sensitive action. Check with your HR/Benefits Office or the SBO website (Policies and Procedure section) for more information.*

Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of enrollment in other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents involuntarily lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. To request special enrollment or obtain more information, contact your HR/Benefits office or the Statewide Benefits Office at 1-800-489-8933 or at benefits@delaware.gov.

*Requests for special enrollment rights must be made within 30 days of the date of the qualifying event. Qualifying events are involuntary loss of eligibility for other coverage (or if the employer stops contributing to the other coverage), or gaining a new dependent through marriage, birth, adoption, custody or placement for adoption. Check with your HR/Benefits Office or the SBO website (Policies and Procedure section) for more information.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

Additional information regarding your benefits, as well as a HIPAA Privacy Notice and Special Enrollment Rights for Individuals Eligible for the Delaware Health Children Program (CHIP), is available online at de.gov/statewidebenefits or by contacting your HR/Benefits Office.

CERTIFICATION (everyone must sign and date)

By my signature below, I hereby certify the benefit elections and statements made on this form are true and my choice. I have completed the required forms necessary to enroll in all the benefit elections chosen. I understand that, by completing and signing the required forms, I am affirming that any dependents noted are eligible dependents as defined by the State's Eligibility and Enrollment Rules (found on the SBO website section 2.01) and that I am making a binding election with regard to my benefits for the current plan year unless I have a permissible family status change as defined by the Internal Revenue Service or I terminate employment with the State of Delaware.

EMPLOYEE SIGNATURE: ____ **DATE:** ______________________

Employee/Subscriber's Initial ______ **Date** _______

When enrolling or dropping coverage based on a qualifying event, the employee must provide a personalized document from the employer, former employer, or other entity or a copy of the individual's COBRA notification as proof that the qualifying event occurred. The document must contain the full name of the individual for whom coverage was lost or gained, reason for loss or gain, the plan type (medical, dental and/or vision) and the corresponding effective date(s).

The HR/Benefit Representative will not process your enrollment change request without the required supporting documents which must be submitted in a timely manner.

Code	Scenario	Required documents*
A	Adding a newborn born to employee or employee's spouse	Completed enrollment change form, legal birth certificate (certificate must include name of employee or employee's legal spouse or civil union partner) & copy of social security card. Hospital issued documents will not be accepted.
B	Adding a new spouse	Completed enrollment change form, legal marriage certificate & copy of social security card. Church issued certificates will not be accepted.
C	Adding a child based on legal or permanent guardianship	Completed enrollment change form, court ordered guardianship document, a statement of support form, legal birth certificate & copy of social security card. Notarized letter from parent of child will not be accepted.
D	Adding a step-child	Completed enrollment change form, legal birth certificate (certificate must include name of employee's legal spouse or civil union partner as parent), a legal marriage certificate & copy of social security card. Church or hospital issued documents will not be accepted.
E	Adding an adopted child	Completed enrollment change form, adoption paperwork noting date of adoption, birth certificate & copy of social security card.
F	Adding a child placed for adoption	Completed enrollment change form, placement document from adoption agency noting date child is being placed for adoption, birth certificate & copy of social security card.
G	Adding a child based on court order	Completed enrollment change form and official court order.
H	Enrollment based on loss of coverage	Required forms noted in applicable scenario (A, B, C, etc.) plus proof of loss from employer, plan or COBRA administrator. The document must include the reason an INVOLUNTARY loss of coverage, plans (medical, dental or vision), names of who was covered and the termination date(s). Resignation of employment is also considered an acceptable reason for loss of coverage.
I	Enrollment based on spouse's (also State of Delaware employee) loss of State share.	Items noted in "B".
J	National Medical Support Notice (Part A & B) Order or Subpoena	This is only HR reps who are enrolling employees and dependents based on an official order that includes child(ren) dates of birth and social security numbers.

Enrollment may be processed pending receipt of the social security number confirmation.

HR Use Only:

Date Received at Agency: ____________________ Human Resources/Benefits Officer:___________________________________

Employee/Subscriber's Initial ______ Date _______