



# City of Boulder | Mid-Year Benefits Change Form

Please return completed/signed form to Human Resources

[HRSubmitForms@boulder.colorado.gov](mailto:HRSubmitForms@boulder.colorado.gov)

or 3065 Center Green Drive

Eff. Date: \_\_\_/\_\_\_/\_\_\_  
 Eff. Pay Period: \_\_\_\_\_  
 Employee ID#: \_\_\_\_\_

## EMPLOYEE INFORMATION

Printed Name (First, Middle Initial, Last) \_\_\_\_\_ Social Security Number \_\_\_\_\_

### MID-YEAR ACTIONS

The changes listed below are allowable at any time during the year and do not require a special life event.

CHANGE – Any Time	
<input type="checkbox"/> Name <input type="checkbox"/> Address/Phone <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Retirement Savings	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Life Ins. Beneficiary Change <input type="checkbox"/> Disability Insurance <input type="checkbox"/> Legal Plan Coverage <input type="checkbox"/> Other (explain in comments box)
Comments: _____	

#### **Name Change**

Current Name (First, Middle Initial, Last) \_\_\_\_\_

New Name (First, Middle Initial, Last) \_\_\_\_\_

Bring new social security card to Human Resources front desk for confirmation and copying.

#### **Address/Phone Change**

*New Information:*

Street Address \_\_\_\_\_ City, State Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Health Savings Account (HSA)		
HSA administered by Optum Health Bank		
<input type="checkbox"/> Enroll, requires an online application <input type="checkbox"/> Cancel Contributions <input type="checkbox"/> Increase or Decrease contributions ( <i>no end date</i> ) New percentage of payroll _____% New dollar amount per pay check \$ _____	<input type="checkbox"/> ONE TIME contributions ( <i>one check</i> ) One-time amount of \$ _____ , during pay period* _____ . After the one-time contribution, I would like to contribute this amount per pay check \$ _____	<input type="checkbox"/> I would like to make multiple contributions for a specific range of time. ( <i>several checks</i> ) Amount of \$ _____ , <input type="checkbox"/> from pay period* _____ to pay period* _____ or <input type="checkbox"/> A set number of pay checks # of checks _____ After the one-time contribution, I would like to contribute this amount per pay check \$ _____

\* To make changes for a *specified* pay period, this form must be submitted by the same date timesheets are due for that pay period. For the current payroll calendar, please visit the Human Resources intraweb page.

Supplemental Retirement Savings	
<b>457</b> plan administered by ICMA <input type="checkbox"/> Enroll, requires a supplemental form <input type="checkbox"/> Cancel contributions <input type="checkbox"/> Increase or Decrease contributions New percentage of payroll _____% New dollar amount per pay check \$ _____	<b>401(k)</b> plan administered by PERA <input type="checkbox"/> Enroll, requires a supplemental form <input type="checkbox"/> Cancel Contributions <input type="checkbox"/> Increase or Decrease contributions New percentage of payroll _____% New dollar amount per pay check \$ _____

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 Employee ID#: \_\_\_\_\_

<b>Additional Life and Accidental Death &amp; Dismemberment Coverage</b>		
<input type="checkbox"/> Enroll/Increase Amount  <input type="checkbox"/> Cancel  <input type="checkbox"/> Update Beneficiaries  <p style="font-size: small;">*Review the plan certificate for details on coverage amounts at various ages and for benefits for dismemberment.</p>	<p>Additional Life purchased through payroll deduction:</p> <p>Mid-Year requests to increase coverage require a supplemental form for medical underwriting approval.</p> <p>You may elect spouse coverage up to 100% of the amount requested for the employee.</p> <p>Election Amount for Coverage on Employee  <i>(minimum \$10,000, maximum \$300,000)</i>                      \$ _____</p> <p>Election Amount for Coverage on Spouse <i>(minimum \$10,000, maximum \$300,000)</i>                      \$ _____</p>	<p>Additional Life purchased through payroll deduction:</p> <p>You may elect up to \$10,000 on your children. The entire amount is guaranteed issue.</p> <p>The cost is the same, no matter the number of children you have.</p> <p>Election Amount for Coverage on Child(ren) <i>(You may elect \$2,500, \$5,000, \$7,500, or \$10,000)</i>                      \$ _____</p>
<p>Beneficiary Designation: The employee is automatically the beneficiary on Spouse and Child coverage amounts. Below please designate your primary and contingent beneficiaries.</p>		
<u>Primary</u>		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:
<u>Contingent</u> (Only if all primary beneficiaries pre-decease you)		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:

**Note:** A beneficiary can be a person, an estate, a trust or an organization.

<b>Long Term Disability Coverage</b>
<p>Long Term Disability provided by the city: The coverage is 50% of the employee's salary. Management/Non-Union employees pay 100% of the premium. For BMEA employees, the city pays the premium for full-time employees (premium share from the city is prorated for part-time employees). IAFF and BPOA members are covered by FPPA for disability.</p> <p><input type="checkbox"/> Enroll - Mid-Year requests enroll require a supplemental form for medical underwriting approval.</p> <p><input type="checkbox"/> Cancel</p>
<b>Legal Support Plan</b>
<p><input type="checkbox"/> Enroll, requires a supplemental form</p> <p><input type="checkbox"/> Cancel</p>

**Signature for Insurance Carriers**

I confirm that the information I have provided on this form is complete and accurate.

I understand that the benefit plans that I have selected provide reimbursement for certain costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or expenses which I have incurred may not be covered by my benefit plan.

I understand that the terms of the contract between the insurance carrier and my employer may not allow late enrollment for me and my dependents.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention products or services that might be valuable to me and otherwise as permitted by law. I understand that my information on benefits may be combined in aggregate at the carrier level with other member's information so that it is no longer individually identifiable and can be used for commercial and other purposes.

I authorize payroll deduction of any applicable employee premiums for these benefits.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Employees working in standard positions but working less than 20 hours per week are not eligible to participate in any of the above insurance plans.

If you are interested in AFLAC coverage, please contact our representative directly to discuss enrollment or changes.