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	MARITAL STATUS / EMPLOYMENT STATUS
			☐ M ☐ F	MARITAL STATUS: ☐ Married ☐ Single EMPLOYMENT STATUS: ☐ Active ☐ Retiree ☐ COBRA

STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE	ENROLLMENT TYPE:
				(H)_____ (C)_____	☐ New Hire ☐ Add Dependents ☐ Other Changes

Social Security Number	CHANGE TYPE:	QUALIFYING EVENT	UNION AFFILIATION
__ __ __ - __ __ - __ __ __ __	☐ Change Address ☐ Change Name ☐ **Delete** Dependents ☐ **Add** Dependents ☐ **Drop coverage**	_____ QUALIFYING EVENT DATE: / /	
EFFECTIVE 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
☐ SELF							
☐ SPOUSE							
☐ SON ☐ DAUGHTER							
☐ SON ☐ DAUGHTER							
☐ SON ☐ DAUGHTER							
☐ SON ☐ 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 ___Medco

Following documents were reviewed for dependent eligibility:
_____Marriage Certificate, _____Birth Certificate _____Social Security Card
REVIEWED/APPROVED BY:_____ ***DATE:***_____