The Delaware River and Bay Authority

Qualifying Life Event Benefits Enrollment Form

Please print in all CAPITAL letters **Please fill in the squares completely**

☐ **New Subscriber** ☐ **Adding line of coverage** ☐ **Dropping line of coverage** ☐ **Adding Dependent** ☐ **Dropping Dependent**

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Last Name	First Name	MI	Title

Street Address **Number**	Street Address Name	Apt #

City	State	Zip

Last 4 digits of Social Security #	Home Phone #	Gender	Marital Status
X X X - X X -		M F	☐ S ☐ M

Qualifying Event Type (Choose one (1) from dropdown below): Birth

Qualifying Event Date (MM-DD-YY):

Form must be returned within 30-days of the QE Date including documentation of the event, else you must wait until next OE.

2

	Last, Full First, M.I.	Social Security #	Birth Date	Gender (M/F)	Disabled (Y/N)
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) _____ Effective Date (Part B) _____

Is your legal spouse eligible for coverage under another employer-provided group health plan? Yes No

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HEALTH PLAN	DENTAL PLAN	VISION PLAN	FLEXIBLE SPENDING ACCOUNTS	SUPPLEMENTAL LIFE and AD&D
Carrier: Highmark Delaware	Carrier: Delta Dental	Carrier: EyeMed	Carrier: Employee Benefits Corp. (EBC)	Carrier: UNUM
Plan: (check one) ☐ PPO ☐ EPO ☐ HDHP ***Tier: (check one)*** ☐ Employee Only ☐Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ***Or Opt Out:*** ☐Decline Health Coverage	***Tier: (check one)*** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ***Or Opt-Out:*** ☐ Decline Dental Coverage	***Plan: (check one)*** ☐ Base ☐ Buy-Up ***Tier: (check one)*** ☐Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐Employee + Family	☐ **ELECT Healthcare FSA** $2,700 Plan Year MAX. Annual Contribution $_____ ☐ or Decline HCFSA Coverage ☐ **ELECT Dependent Care FSA** $5,000 Plan Year MAX. Annual Contribution $_____ ☐ or Decline DCFSA Coverage	**Employee Life / AD&D** ☐Decline Supplemental Life **Spouse Life / AD&D** ☐Add Spouse Life (may be subject to EOI) Increments of $5k ($5k up to $25k) Coverage Amount $_____ ☐ Decline Spouse Life **Dependent Child Life / AD&D** ☐ Add $10,000 per child Life (may be subject to EOI) ☐Decline Child Life

4 OTHER INSURANCE INFORMATION – Required to Opt Out of Health Plan

If you Decline Health Coverage, ***you MUST attach a copy of your Other Health Plan ID card to this form*** proving you have coverage elsewhere.

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CERTIFICATION: I hereby accept on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Benefits Representative before signing this Election Form.

THIS IS NOT AN APPLICATION FOR INSURANCE

EMPLOYEE SIGNATURE_____ **DATE** _____

You can either digitally sign this form by following the prompts online or you can print this page. In either case, the form must be signed and dated and submitted to the Benefits Office via inter-office mail or emailed to payroll.benefitsadmin@drba.net, as soon as possible.

BENEFITS ADMINISTRATION SIGN-OFF _____ **DATE** _____