Section 1: Personal Info	ormation			
NameLast Name	First Name		on Number	
		M.I. <u>Gende</u> r:	Assigned ID Male Female	or Social Security Number
Month Important! Be sure to verify the	Day correct format of your address	Year at http://zip4.usps.com/	zip4/welcome.jsp.	
Street Address			P.O. Box	
City		State	Zip + 4	
State E-mail:		Persona	ıl E-mail:	
State Phone: ()	Personal Phone:	()	<u>M</u> obile	
Section 2 : Reason For	This Enrollment or Ele	ection Change Red	quest	
Check the box that applies. The	numbers in parentheses are fo	or agency use.		
Open Enrollment (56) Initial Enrollment for Newly Eligi	ble Employee:	(01))	
	cumentation to Support the Even and attach the appropriate supp	nt	dicated. Date of Event:	
•		C		MONTH/DAY/YEAR
		ible dependents.		
		up to \$2,750.)		
Amount per regular paycheck				

A10459 (3/2020)

I do not wish to participate in health care coverage (W) No change to my current health plan selection and family members/membership level (If you check either box above proceed to Section 5.)
A. Health Plan Selection – Check the box that applies

No change to m	y current nealth care plan
STATEWIDE HE	ALTH PLANS

Administered by Anthem Blue Cross Blue Shield*
COVA Care (with preventive dental) (ACCO)
COVA Care + Out of Network (ACC1)

Administered by Aetna*
COVA HealthAware (with preventive dental) (CHA)
COVA HealthAware + Expandel.3 (ar2 (a)-19.2 (n)-14.2 (d)-20.9 (e)-2