



Stanislaus County Universal Enrollment/Change Form

Please complete this form in its entirety when enrolling or making changes. Refer to your Benefits Summary for information on your benefit options. Check the option for each of your choices. Enter the dependent information if necessary. Indicate your Primary Care Physician's Name and ID#. You will also need to complete a County Benefit Enrollment form for an option code change. If there is a Family Status Change, you must return completed forms within 30 days of the qualifying event.

Employee General Information

| | | | | | | |
|---|-----------------------------------|---|--|--|----------|----|
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> New Hire | <input type="checkbox"/> Change in Status | Effective Date: / / | Reason: | Emplid: | |
| Last Name | | First Name | | New Last Name (If applicable) | | MI |
| Address | | | City | State | Zip Code | |
| Phone# Home | Work | Sex <input type="checkbox"/> Male | Marital Status <input type="checkbox"/> Single | Date of Birth / / | | |
| Social Security No. - - | | <input type="checkbox"/> Female | <input type="checkbox"/> Married | Date of Hire / / | | |

Medical/Dental/Vision Plan Election

| | | |
|---|--|---|
| Medical <input type="checkbox"/> Health Plan of San Joaquin GRP # STC-NET01 <input type="checkbox"/> Kaiser Permanente GRP # 37295 <input type="checkbox"/> PacifiCare HMO GRP # 403218 <input type="checkbox"/> PacifiCare POS GRP # 513272 | Dental <input type="checkbox"/> Stanislaus Dental Foundation GRP # 3001 | Vision <input type="checkbox"/> Vision Service Plan GRP # 0045000-0002 |
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Dependent Information

List all family members to be covered each time you complete this form. Attach separate sheet for additional dependents.*
 Please indicate primary care physician's name and ID#, if not complete, you will be automatically assigned. For a list of physicians, refer to the directory provided. Select coverage for each dependent

| Last Name | First Name | Social Security Number | Relationship | Date of Birth | Sex | If change (check one) | | Primary Physician Name | Primary Physician ID# <small>(Not required for Kaiser)</small> | Established Patient | | Medical | Dental | Vision |
|-------------|------------|------------------------|--------------|---------------|-----|--------------------------|--------------------------|------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | | | | Add | Delete | | | Yes | No | | | |
| 1. Employee | | Included Above | Self | N/A | N/A | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | | | Spouse | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

***Dependents age 19 and over require a Certification of Dependent Status Eligibility form be completed to indicate full-time student status or permanent disability.**

