# Stanislaus County Benefit Enrollment Form 2016- Early Retirees

Please complete this universal benefit enrollment form in its entirety when enrolling or making changes to your Medical Benefit. Refer to your Benefit Guide for detailed information on your medical plan options. Check the box next to the option of your choice. Enter all dependent information if necessary. If there is a Life Event change, submit this completed form and backup documentation within 30 days of the qualifying event. **Marriage and/or Birth Certificates are required when enrolling a new Dependent in a Health Plan.**

## 1. Main Subscriber's General Information

| ☐ Open Enrollment | ☐ Life Change- Type ____________ | Change Date: / / | ID #: For office use |
|---|---|---|---|
| Last Name: | First Name: | MI | New Last Name: (If applicable) |
| Address: | City: | State: | Zip Code: |
| Phone # Home: | Cell: | Sex: ☐ Male ☐ Female | Date of Birth: / / |
| E-Mail Address: | Marital Status: ☐ Married ☐ Single | Social Security #: – – | |
| Main Subscriber: ☐ Retiree ☐ Spouse ☐ Beneficiary | Are you covered by Medicare Parts A & B? ☐ Yes ☐ No<br>If you marked Yes, you are not eligible to enroll in this plan. | | |

## 2. Medical Plan Options and Monthly Premiums

| Coverage Level | SCPH or Anthem | |
|---|---|---|
| | **HDHP** | **EPO** |
| **Subscriber** | ☐ $623.77 | ☐ $745.84 |
| **Subscriber +1** | ☐ $1,247.53 | ☐ $1,491.69 |
| **Subscriber +2 or More** | ☐ $1,684.19 | ☐ $2,013.79 |

## 3. Dependent Information

List all dependent information below. **Marriage and/or birth certificates required for dependents enrolled in a medical plan.**

| Dependent Name | Social Security # | Relationship | Date of Birth | Sex | Add | Delete |
|---|---|---|---|---|---|---|
| 1. | | | | | ☐ | ☐ |
| 2. | | | | | ☐ | ☐ |
| 3. | | | | | ☐ | ☐ |
| 4. | | | | | ☐ | ☐ |

## 4. Acceptance and Payment Agreement--Please read the following and acknowledge by signing below:

I understand that I may continue my medical benefits for myself and my covered eligible dependents, upon retirement. In order to qualify, I know that I, and/or my dependents, cannot be covered by another group health plan through another source, including Medicare. I understand that when I, and/or my dependents, turn 65, I, and/or my dependents, will be canceled from this medical plan.

I understand that by signing below, I am acknowledging my enrollment in the medical plan option selected for the plan year indicated on this enrollment form. Should changes take place affecting eligibility of this enrollment, I will immediately inform Stanislaus County Employee Benefits of the change. Any mis-statements or omissions may result in future claims being denied and/or the policy being rescinded. I am entitled to a copy of this signed authorization for my files.

## 5. Recipient of retirement monthly benefit:

☐ Retiree ☐ Spouse ☐ Beneficiary

| Last Name: | First Name: | Social Security #: – – |
|---|---|---|

☐ I agree to have my monthly medical plan premium of $______________ (total of premium from side 1 of this form) deducted from my StanCERA retirement check. I understand that StanCERA will not take partial deductions from my retirement check. If there is not enough money to cover my full medical plan deduction, I agree to pay Stanislaus County directly by check or money order, the total premium owed, by the 1st of every month or my coverage may be canceled.

| Retiree Signature | Date |
|---|---|

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